9. Care Coordination

Please explain how you propose to execute Section 9 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience

Overview

Today, too many vulnerable individuals, especially those with both physical and behavioral health conditions, receive care in fragmented systems with little to no coordination across providers. AmeriHealth Caritas Family of Company's (AmeriHealth Caritas') next-generation model of care applies a person-centered approach that addresses the physical, behavioral health, pharmacy management and social needs of our members. AmeriHealth Caritas Iowa will collaborate with the Iowa provider community and supporting social service resources to address our members' care coordination needs. We will implement strategies to extend care management into the neighborhoods where our members live-to engage them where they are and ensure they are connected to services. We have a 30 year history of designing fully-integrated coordinated care programs that improve health outcomes and empower our members to live healthier, happier lives.

- AmeriHealth Caritas Iowa will implement its Integrated Healthcare Management (IHM) program to meet the variable and unique needs of Iowa members.
- Our IHM program has a strong track record of improved clinical and financial outcomes, and member satisfaction in the other states we serve.
- AmeriHealth Caritas Iowa has a local approach: our model is designed to leverage and strengthen existing community infrastructure and assets.

AmeriHealth Caritas' Integrated Healthcare Management (IHM) program is designed to meet members' diverse and unique needs. Our IHM program is population-based and person-centered — focused on increasing self-management capabilities whenever possible.

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There are six core components to the AmeriHealth Caritas IHM program, aimed at serving the diverse needs of all our adult and pediatric members, whether they are low-risk members who require surveillance for preventive services or high-risk utilizers who require intensive engagement and intervention. AmeriHealth Caritas' Care Management programs include:

- Pediatric preventive health care.
- Episodic Care Management for those with short-term or intermittent needs.
- Bright Start® maternity management.
- Complex care management for those with complex and long term service support (LTSS) needs.
- Rapid Response team for urgent needs.
- Team-based community care management to engage our hardest to reach members where they are.

Behavioral health, disease management and social supports are integrated into each of these components to provide holistic care.

AmeriHealth Caritas employs a wide array of chronic disease management and wellness programmatic support, including diabetes care, chronic asthma management, HIV, coronary artery disease, congestive heart failure, depression, sickle cell disease management, pregnancy and well child care. Algorithms to address each of these areas are embedded within the care manager's workflow, as indicated for each member enrolled in a care management program.

AmeriHealth Caritas Iowa's IHM program will be tailored to meet the unique needs of Iowa's Medicaid population. For example, knowing that Iowa has relatively few OB/GYN providers for the member population, our IHM staff will actively work to identify and engage all pregnant members in our Bright Start® program early in their pregnancies and focus on ensuring timely access to OB/GYN care through innovative strategies, including centering programs and telemedicine support. AmeriHealth Caritas Iowa will also work to improve transitions of care for all of our members, including LTSS members, to ensure that all necessary services are coordinated and members receive the most appropriate care in the most appropriate setting. Additionally, we will make sure that increasing the number of members enrolled in Health Homes is a core performance metric for our care management program, given that effectively coordinating with existing Health Home programs is a core goal in Iowa's Healthiest State Initiative.

Our IHM program has a strong track record for clinical and financial outcomes, and member satisfaction in the other states we serve. We fully expect to maintain those same standards of excellence for AmeriHealth Caritas Iowa. For example:

- In 2014, members with congestive heart failure experienced fewer admissions per 1,000 members compared to 2013, with the largest drops seen in our southeast Pennsylvania, Louisiana and South Carolina affiliate plans, 21 percent, 16 percent and 8 percent, respectively. For members with secondary cardiovascular disease, admission rates dropped by 10 percent to 20 percent in our two Pennsylvania and Louisiana plans.
- Member-reported wellness using a 12-item short form across six of our plans in 2014 showed improvement in every area of the tool, with greatest improvements in member assessment of general health, energy level, and feeling calm and peaceful.
- In a financial outcomes review by Reden and Anders (now part of United Healthcare), our care management program in Pennsylvania achieved $122 per member per month in gross savings, which equated to over 9 percent of projected costs and $6.1 million in total savings within a 12-month period.
- Our Community Care Management program in our South Carolina affiliate achieved a 15 percent reduction in total cost of care within six months of enrollment.

AmeriHealth Caritas is successful in conducting basic health screenings for assigned members through a combination of mail, telephonic and community based outreach. We are successful in engaging 98 percent of members contacted for care management support. We augment initial health risk screening with advanced data mining techniques, referral pathways and event triggers. We apply proprietary claims analytics queries to identify the highest-risk members in our overall population. For example, certain behavioral health diagnoses (e.g., severe and persistent mental illness, alcohol or other substance use), social barriers to care (e.g., lack of public transportation), and polypharmacy are the top predictors for poor health outcomes. For members identified with these and other special needs, we perform an additional comprehensive health risk assessment, and then work with the member and other relevant stakeholders to create an individual plan of care and track its impact. Our comprehensive model allows

members to move seamlessly from one component of the program to another, as necessary, depending on the member's own unique level of need and priority.

Our model leverages person-centered decision support to drive communication and care plan development through a multidisciplinary approach to management. The IHM program includes reassessing and adjusting the care plan and its goals as needed. AmeriHealth Caritas uses a comprehensive population health management platform, Jiva™ (ZeOmega) to integrate all of our medical management utilization and care management departmental functions, including behavioral health and pharmacy management. Authorizations-based medical economics reports and operational reports to monitor staff efficiency are also generated from this system to proactively manage care.

The AmeriHealth Caritas IHM team includes nurse case managers, social workers, care connectors (community health workers), clinical pharmacists, behavioral health clinicians and plan medical directors. Primary Care Providers (PCPs), specialists, members and caregivers (parents/guardians) are recruited to actively participate. Care management services are performed locally, in every state in which we operate. Under the direction of a medical director, the primary nurse case manager assigned to the member collaborates with other team members and the PCP to effect the care plan. Care coordination is achieved through clear communication and a commitment to understand the 360-degree view of our patient. This work is supported by a web-based platform that can be accessed by patients, caregivers and providers. The team works to meet members' needs at all levels in a proactive manner that is designed to maximize health outcomes.

Our model of care is designed to leverage and strengthen existing community infrastructures and assets. As we enter any market, we conduct a thorough inventory of available programs and supports. This allows us to draw on those programs to supplement the services available through the member's Medicaid benefit package. We also seek ways to partner with community organizations to strengthen their offerings. For example, we provide diabetes screening services at church gatherings and anti-violence education programs for after-school organizations.

We also work creatively to enhance our providers' ability to deliver high quality healthcare services. Our Network Account Executive team provides education and practice transformation support for providers looking to build patient-centered medical home (PCMH) or Health Home capabilities. Our clinical educators provide training for office staff on behavioral health screening and interventions. Our team-based community care management approach places care managers and care connectors in the community and at provider sites. In addition to improving our ability to effectively engage complex members in their healthcare, these efforts extend the provider's reach beyond their office walls.

"The Keystone First [AmeriHealth Caritas Iowa's southeastern Pennsylvania affiliate] Community Case Management team has been instrumental in the management of the most medically and social-economically complicated patients of our practice. The opportunity to collaborate with nurses, social workers and community care workers from Keystone First, and more closely work with the patients themselves, allows us to better exchange information and combine resources. The results are expanded services and improved coordination of care for our challenging patients."

George Valko, M.D.
The Gustave and Valla Amsterdam Professor of Family and Community Medicine
and Vice Chair for Clinical Programs and Quality
Thomas Jefferson University Hospitals

Holistic Approach to Member Care

Integrated health care management programs address members' comprehensive needs.

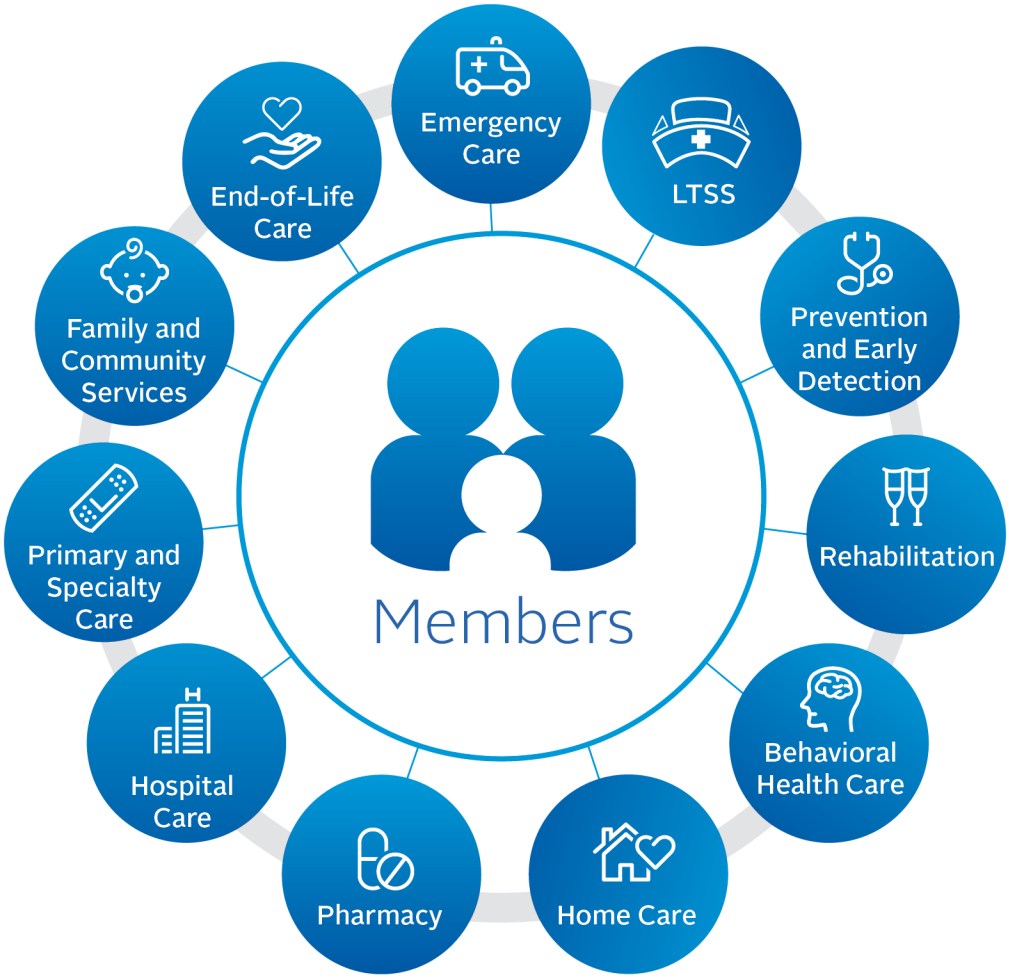

Exhibit 9.0-A: AmeriHealth Caritas' Care Management Model

9.1 General

1. Describe proposed strategies to ensure the integration of LTSS care coordination and Contractor-developed care coordination strategies as described in Section 9.

Members currently receiving or eligible for LTSS will automatically receive all complex care management services that non-LTSS members receive. In order to maintain a smooth member experience, each member receiving LTSS will work through a single primary care manager (the member will not have a

separate LTSS and CCM care manager). In addition, each LTSS recipient will receive ongoing face-to-face care management assessments and interventions with personalized care plans to meet their specific needs. AmeriHealth Caritas Iowa will contract with LTSS providers to deliver community-based services to ensure stability and long-term successful integration of these members in the communities they live.

AmeriHealth Caritas Iowa will establish communication points and referral pathways for organizations and individuals identifying members for LTSS assessment, including but not limited to:

- **Member** — Information on the LTSS program and criteria to be included in member materials and on our plan website. Members can call our toll-free Call Center of Excellence (CCOE) to request an evaluation.
- **Providers** — Information on the LTSS program and criteria will be included in the Provider Handbook and on our plan website. Providers can call our toll-free Rapid Response line or submit a fax request to have a member evaluated.
- **Data review** — Available utilization data (including hospital admissions) and claim data will be aggregated and reviewed to identify members who may meet the eligibility criteria for any of the seven Home and Community Based Service (HCBS) waivers or the LTSS, including:
    - Targeted diagnoses, such as multiple chronic conditions (hypertension, overweight, heart disease, diabetes, asthma, substance abuse, mental health condition, HIV, intellectual disability); brain injury (neoplasm, anoxic brain damage, hemorrhage, or other debilitating cerebrovascular disease); physical disability (quadriplegia, paraplegia, or other physical impairment) or serious emotional disturbance.
    - Targeted age range in combination with the above diagnoses, based on the requirements of each HCBS waiver.
    - Utilization pattern indicating member needs are not being met through the traditional Medicaid healthcare delivery infrastructure.

We will comprehensively educate Care Management and Utilization Management (UM) teams on LTSS availability and referral triggers to facilitate internal referrals of potential LTSS candidates to the LTSS assessment team. The LTSS assessment team will coordinate the information collection and in-person assessment of the member's care needs. With the assistance of the care connector assigned to the member's interdisciplinary care team, the care connector will facilitate referrals and assist the member to connect with available community services. To support members in need of complex community service support or assistance navigating bureaucratic requirements, the care manager will involve one of AmeriHealth Caritas Iowa's social service experts. Focusing strictly on mapping and building relationships with community organizations and government programs (such as subsidized housing agencies), AmeriHealth Caritas Iowa's social service experts will help ensure that members can access supplemental services to support the member in the community.

As part of the assessment process, we will coordinate and collect information from existing agencies and service providers involved in the member's care. AmeriHealth Caritas proactively forms relationships and establishes bi-directional contact points with organizations involved in the provision of LTSS care coordination. There will be several strategies in place throughout the care coordination continuum to ensure integration of LTSS care coordination. For example, In Michigan, we are working closely with the Michigan Area Agencies on Aging to provide in-home support for our Medicare Medicaid Program (MMP) demonstration members.

- During the assessment phase, we will collect information on all existing support being provided, services that are required and emergency plans. This compendium of shared information helps us

form a complete view of the member, ensures that we do not duplicate services or supports, allows us to identify any additional services that may be required and allows us to incorporate and track all of these services in our care plan.

- Once information has been collected, the care manager will reach out to community caseworkers, and together, they will collaborate to develop a single patient-centered care plan.
- As in our other markets, based on member's need, we will establish routine care conferences, including representatives from the member, providers and LTSS organizations.
- We will also make the member's care and service plans available to individuals, providers and organizations involved in the member's care, with the member's permission. This information can be accessed over our secure web portals.

We are working actively with key stakeholders in Iowa to shape our program to meet State needs. For example, we are working with the Iowa Association of Community Providers to develop a collaborative partnership to address the needs of disabled Iowan children and adults. We have also signed a Letter of Intent (LOI) with the Iowa Area Agencies on Aging (AAAs) in order to have them serve as a core vendor for waiver services. For greater detail on our LTSS care coordination strategies, please see Section 4 of our response.

9.1.1 Initial Screening

1. Describe your plan for conducting initial health risk screenings.

Health risk assessments (HRAs) are a valuable tool for helping members identify their health needs and prioritize their health goals. Information gathered during the completion of an HRA can be used to foster better communication between the member, the provider and the health plan, which can lead to engagement, empowerment, improved health outcomes and satisfaction with the healthcare experience.

AmeriHealth Caritas Iowa will conduct initial health risk screenings for:

- New members, within 90 days of enrollment for the purpose of assessing need for any special healthcare or care coordination services.
- Members who have not been enrolled in the prior 12 months.
- Members for whom there is a reasonable belief they are pregnant.

We will align our tools, messages and incentives closely with existing programs in Iowa, such as linking with the AssessMyHealth.com portal (member risk self-assessment) and supporting Iowa's Healthiest State Initiative. As outlined in section 10.2 of this response, many of our community education programs and several of the behaviors linked to our member incentive CARE card program mirror Healthiest State campaign goals.

Based on our experience with states with similar urban/rural composition and population density (e.g., South Carolina non-dual and dual demonstration programs), we will utilize a multi-channel approach to complete screenings.

New members and members who have not been enrolled in the prior 12 months will be automatically flagged in the Jiva population health platform upon enrollment, which triggers initial screening outreach. We will contact our members through:

- **Mail** — For all members, the initial HRA will be included as part of their mailed welcome packet. Members can complete the HRA and mail it back in the provided self-addressed stamped envelope.
- **Telephone** — The initial HRA can also be completed through inbound or outbound calls. All telephonic interviews will be conducted by clinical and member services staff.
- **Inbound calls** — Members have the option to call a toll-free number and complete the assessment by phone.
- **Outbound calls** — Member enrollment files will be provided to the Rapid Response Outreach team (RROT) for telephonic outreach to complete the health risk screening. During the initial phase of the contract, AmeriHealth Caritas Iowa plans on supplementing our phone outreach efforts with a contractor. Additionally, our member service unit will make welcome calls to all new members. During this call, we will work with the member to complete the HRA if it is not already in the system. The plan will also take advantage of any member contact through both inbound member and outbound calls to conduct an assessment.
- **Member Portal** — Through our main website, Members will also be able to access our secure Member Portal (website) to complete the initial screening. All members will have access to our Member Portal, which allows members to establish a user ID and password for secure access to a wealth of information.

For members who have not completed an HRA after 30 days, we will send them a postcard reminder with a toll-free number to call. At the same time, the member service team will continue outreach calls to members who are missing the HRA.

For members who have not completed an HRA after 60 days, AmeriHealth Caritas' Rapid Response and Community Outreach Solutions (COS) teams will provide additional support. Staff reviews claims history for members we have been unable to reach via phone, and performs outreach to providers and pharmacies that the member may have used in order to obtain the member's most up-to-date contact information. For members who have any high-risk markers, which might include a behavioral health diagnosis or prior use of community-based services, a COS representative will attempt to contact the member in-person using the best known address information.

Members who have not completed an HRA after 90 days are referred to our COS team for an in-person screening. Members that have not completed the initial health risk assessment will have a care connector sent to their home to complete the screener in person. We will use the Community Outreach Solution (COS) team workers for the in-person HRA. We will have COS staff stationed throughout the state to maximize our presence in the community. They will perform a variety of functions, including in-person follow-up for missing HRAs, post-discharge visits to high-risk members, coordinating community health and awareness events, establishing relationships and supporting local community agencies

Members for whom there is reasonable belief may be pregnant

Members we believe may be pregnant — either through presumptive eligibility category or other data inputs — will be contacted by our Bright Start maternity team to complete the HRA, ensure connection to prenatal care and begin the Bright Start program. Members using our mobile app will receive a text message asking them to call the Bright Start team to complete the HRA and begin with the program. We will also use the additional strategies outlined below in order to help identify members who are pregnant:

- "Are you or could you be pregnant?" is a standard question asked as part of RROT contact with a member and is also as part of the overall HRA telephonic screen.

- Obstetrics (OB) practitioners will be financially incentivized to submit Obstetrical Needs Assessment Form (ONAF) immediately following the member's first prenatal visit.
- AmeriHealth Caritas Iowa will mine administrative claim data for pregnancy diagnoses, specific procedure codes (e.g., OB ultrasound) and electronically submitted Logical Observation Identifiers Names and Codes (LOINC) indicating positive pregnancy.
- AmeriHealth Caritas Iowa will mine additional data sources, including pharmacy data for medications prescribed, which might also indicate pregnancy.

2. Submit a proposed initial health risk screening tool. Exhibits and attachments may be included.

AmeriHealth Caritas Iowa will utilize Wellsource®, an industry leader in health risk assessments and wellness programs, for our HRAs. We chose Wellsouce as it will provides a number of key benefits for the Iowa population. Their tool is National Committee for Quality Assurance (NCQA)-certified as a Health Appraisal and Self-Management Tool.

Our HRA tool will be available in both an online version and in a paper format. AmeriHealth Caritas Iowa understands that all members may not have reliable Internet access in rural locations in the state, and some members may prefer to complete the HRA in a hard copy document. The added benefit of having a printed version available is that the HRA materials can be included in membership mailings, such as new member welcome packets, and can be mailed directly to the Care Management team.

An additional feature of the Wellsource HRA is the ability to add customized questions to the assessment. These questions will be tailored to address specific areas of focus and unique health concerns relative to the Iowa population. For example, AmeriHealth Caritas Iowa will include additional questions to identify Member behavior related to physical activity and produce consumption to support our ability to deliver person-centered interventions and education related to Iowa's Healthiest State initiative. Questions can be modified over time, as foci change or new programs are launched. (Example questions can be seen in Exhibit 9.1.1-A)

We have also selected the Wellsource HRA tool because of its ease of use and its consumer-friendly summaries, which are provided to the member in an easy-to-read language, appropriate for Medicaid populations. For members with limited health literacy, a companion video is available. The video provides information about how to use the member's individual report in an audio and visual format called the Healthy Living Guidelines. The video walks the member through each section of the individual report, explaining scores and educating members on how to achieve optimal health based on their own results. The video is can be streamed online for members with Internet access or viewed on DVD. For Members without internet access, we will mail the DVD upon request.

3. Describe the methods that you will use to determine whether changes in member health status warrant subsequent screening.

AmeriHealth Caritas Iowa will deploy three key methods to determine whether changes in member health status warrant subsequent screening:

Data Mining

AmeriHealth Caritas Iowa will mine administrative claims data for utilization history to determine whether a member potentially needs subsequent screening (e.g., multiple inpatient admissions, emergency room visits, inpatient admissions or emergency room visits for conditions that are typically managed in the outpatient setting, such as diabetes, asthma and otitis media).

One main indicator we will screen for is a new diagnosis for a member. For example, a need for subsequent screenings would be triggered by new diagnoses appearing in claim data, such as diabetes, asthma, chronic obstructive pulmonary disease (COPD), hypertension, cardiac disease, depression, Attention Deficit Hyperactivity Disorder (ADHD), hepatitis C, substance abuse, pregnancy, and serious mental illness.

Biometric data outside of optimum parameters, such as lab results (e.g., elevated HgbA1c, LDL-C, lead level) and recorded BMI will also serve as a trigger.

AmeriHealth Caritas Iowa will also utilize a predictive modeling capability to identify activities and lack of preventive care visits in a member with certain co-morbidities (e.g., behavioral health) to identify individuals for whom more intensive screening and intervention is warranted. Our analysis will focus on combinations of potentially preventable services (PPS) and admissions (PPAs), medical cost, and specific levels of behavioral health, diabetes and cardiac disease comorbidities.

Solicitation of provider and member referrals

Let Us Know is a program we will market to providers to encourage them to contact the plan about members with a new diagnosis or health status change. Providers can call or fax to request assistance, which will prompt a subsequent screening.

Furthermore, member materials and access channels (e.g., on-hold messaging, Member Portal, mobile application) will remind members that they can contact RROT for assistance accessing care or when their health status changes.

Health Plan Activity

Routine workflows and training for all health plan teams that have contact with members include procedures to connect members who have a change in health status or unmet healthcare needs to RROT for screening and intervention.

4. Describe methods that you will use to maximize contacts with members in order to complete the initial screening requirements.

AmeriHealth Caritas Iowa will make the most of each and every contact in order to help improve member outcomes, including completing the initial screening requirements. We are focused on completing the initial screening in the most optimal way, and on creating an easy experience for Iowa's population. In that critical effort, we have created several different screening options so members' needs can be best met:

- **Prompting contact upon enrollment** — All members' health cards will have a sticker on them that will instruct the member to call RROT to activate the card. When the member calls, AmeriHealth Caritas Iowa will complete the screen and help with the family's healthcare needs. AmeriHealth Caritas implemented this process in our affiliate plan in Washington, D.C. with successful results.

- **Multi-channel outreach** — AmeriHealth Caritas Iowa will provide several additional mechanisms for completion of the initial screening tool. Members can complete the screen on paper and return it via a pre-stamped envelope, call a toll-free phone number or complete the screening using the secure Member Portal.
- **Inbound call alerts ("Make all calls count")** — Whenever the member calls the plan, an alert will pop up for any member who has not completed the initial screen. The Member Service or Care Management staff speaking with the member will then facilitate completion of the screening tool.
- **Family-centered approach** — In cases where more than one family member has coverage, AmeriHealth Caritas Iowa will utilize a family-centered approach. Our associates have the ability to access a "family link," allowing them to view information, including a missing initial screening, for other family members who are participating in the program. The family link within AmeriHealth Caritas Iowa's medical management platform system allows AmeriHealth Caritas Iowa to capitalize on each contact we have with our members. Since the average Medicaid household has 2.5 members, use of family link allows us to double our conversion rate during telephonic outreach.
- **Automated messaging** — Automated voice or text messages are sent to the member's phone number on file as a reminder to complete initial screenings. The phone message gives the member the option for a warm transfer to the Member Services staff to complete the initial screening. Through the text message, members receive a direct phone number they can call for the same service on a dedicated line. Campaign outreaches occur throughout the day and also in the early evening.
- **Member Portal** — All members will have access to a secure Member Portal. As stated above, this tool allows members to establish a user ID and password for secure access to a variety of information, including the online screening tool.

9.1.2 Comprehensive Health Risk Assessment

1. Submit a proposed validated comprehensive health risk assessment tool. Exhibits and attachments may be included.

When a member is identified in the initial screening process as having a special healthcare need, or when there is a need to follow-up on problem areas identified in the initial screening, the screening will be followed up by comprehensive assessment. Accurate and timely comprehensive assessments are an incredibly important piece of care coordination because they help ensure that members are connected to and supported with the right set of supports and services. HRAs are especially important given the rural nature of Iowa, as unmet needs of members in outlying areas may go unnoticed (as we have learned in our affiliate plans in Nebraska, South Carolina, and northeastern Pennsylvania).

The AmeriHealth Caritas Care Management team uses three age and condition-specific assessment tools, depending on whether the member is an adult, child or pregnant woman. A separate tool, discussed in Section 4, is used for members being evaluated for LTSS.

The assessment incorporates subjective findings from the member, such as perception of health (utilizing the SF-12 tool) and PHQ9 assessment. The assessment includes health literacy level, lifestyle choices (such as tobacco use, alcohol and drug use, and weight management), cultural and linguistic needs and contact preferences. The topics addressed through our assessment are listed below:

Health problems	Current health problems. Length of time. Knowledge related to cause and treatment. Providers involved in the member's care (physical health, behavioral health & dental).
Medications	Medications used. Dose/frequency. Understanding of reason for the medication. Allergies.
Cultural and religious preferences	Cultural/traditional or home health remedies. Cultural and religious beliefs and preferences. Language preferences (written and spoken).
Medication barriers	Reasons for not taking medication. Assistance needed for medications.
Awareness	Medication/condition alert bracelet/card. Emergency support system. Advance Directives.
Physician care	Frequency of doctor visits. Date of next appointment. Plan if not feeling well.
Hospital/ER use	History of use (inpatient admissions and emergency room visits). Reason for event.
Functional status	Self-care (activities of daily and independent living). Mobility limitations.
Living Arrangements	Location, access and safety. External activities (including school, educational programs and work).
Health literacy	Problems reading or understanding information.
BMI	Height/weight. Frequency monitored.
Nutrition	Type of diet. Ability to adhere to diet.
Substance use	Tobacco use. Drug use. Alcohol use. Frequency of each.
Lifestyle	Frequency of exercise. Cultural practices.
Health care access	Available transportation. Barriers to care.

Behavioral health	Depression. Anxiety. ADHD.
Cognitive and sensory limitations	Care manager assessment of cognition. Hearing or vision abilities
Condition-specific Target conditions include, but are not limited to: • Asthma. • COPD. • Diabetes. • Heart failure. • Pregnancy. • Sickle cell disease. • Obesity.	For each identified target condition: • Understanding of condition. • Adherence to recommended clinical guidelines. • Lifestyle factors. • Self-management skills. • Presence and management of complications.

Exhibit 9.1.2-A: Health Risk Assessment Topics

Dependent on the findings from the initial screening and/or the above assessment process, the care manager will perform additional focused assessments to address identified physical or behavioral health conditions. Examples of validated tools and topic areas used in that process include:

- Asthma Control Test.
- Behavioral health condition-specific screens, including:
  - Age-based screens for anxiety.
  - Attention Deficit Hyperactivity Disorder (ADHD).
  - Autism spectrum disorders (ASD).
  - Bipolar spectrum disorder.
  - Depression.
  - Post-traumatic stress disorder.
  - Psychotic disorders (e.g., schizophrenia, schizoaffective, etc.).
  - Substance use disorders.
- Diabetes.
- Cardiovascular disease.
- Weight management.

AmeriHealth Caritas' assessment tools comply with NCQA Case Management standards. Attached (at the end of this section) is an example of our comprehensive assessment tools: Attachment 9.1.2-A: Comprehensive Assessment — Adult.

2. Propose the timeframe in which all comprehensive health risk assessments shall be completed after initial member enrollment.

Comprehensive health risk assessments are predicated by the initial member screen. They are completed in a time frame compliant with NCQA guidelines:

- When a member is identified for care management, the member will receive a comprehensive assessment within 30 days. Note: This follows the NCQA requirement for the initial assessment to be completed within 30 days of enrollment into care management.
- As part of the comprehensive assessment, the member will also receive a depression screening within the 30-day window.
- Any high risk condition(s) identified during the initial screen will also be assessed as within 30 days.
- All members who receive a comprehensive screening also receive a quality of life assessment (SF-12) within 30 days. The SF-12 gauges the member's perception of their health and ability to function.

3. Describe how the assessment process will incorporate contact with the member and his/her family, caregivers or representative, healthcare providers and claims history.

Input from claims history

At the start of the assessment, the AmeriHealth Caritas Iowa care manager reviews information from the member's claim-based clinical summary (MCS). The MCS contains information on identified conditions; missing or overdue services (care gaps); recent inpatient admissions and emergency room visits; medications received from the pharmacy; specialty type and visit dates for providers involved in the member's care; radiology procedures and key laboratory results. For pediatric members, the MCS also contains a list of all immunizations and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings in the claim history. As mentioned in the previous section, through the 360-degree member view in AmeriHealth Caritas Iowa's medical management platform, the care manager can also view detailed information for all claims on file for the member.

Input from the member and his/her family, caregivers or representative

The second phase of the assessment involves collecting detailed information from the member and his/her family, caregiver or representative. This interaction can occur over the phone, or for member's engaged through one of AmeriHealth Caritas Iowa's embedded care managers, in person at the provider's office. Assessments for LTSS (discussed in Section 4) are always performed in person.

AmeriHealth Caritas Iowa believes that members should drive their own care to the extent possible. We follow person-centered planning and treatment principles, in conjunction with motivational interviewing techniques, to empower the member to determine who provides input to the assessments and care plan.

Care manager testimonial:

I find that using the Motivational Interviewing approach, in general, helps me engage members because I build a rapport with them before I launch into assessment questions. For example, I might first tell the member I'm calling to see how they've been doing since they got out of the hospital. By the time I introduce our care management services, that member is already engaged in telling their story and generally likes the idea of talking with me again. Plus, many of the assessment questions get answered before they are even asked, so the interaction feels less like an interrogation.

Input from the member's healthcare providers:

The final phase of the assessment involves collecting information from providers involved in the member's care. The care manager contacts the provider via phone, fax or direct message in the Provider Web Portal to solicit information on the member's strengths and needs, along with prescribed medications and treatment plans. When needed, treatment team meetings are scheduled to include the member and any other participants they identify, including providers and the member's natural supports.

9.1.3 Care Coordination

1. Describe in detail your proposed care coordination program including selection criteria and proposed strategies.

AmeriHealth Caritas' IHM program provides a holistic solution across the care continuum and uses a population-based approach to provide comprehensive care coordination services. This fully integrated model allows members to move seamlessly from one component to another, depending on each member's unique needs. From this integrated solution, AmeriHealth Caritas delivers and coordinates case management, disease management and long-term support services.

Our model incorporates a person-centered decision support system that drives communication and care plan development through a multidisciplinary approach to management. The IHM process includes reassessing and adjusting the care plan and its goals as needed. AmeriHealth Caritas uses leading technology to integrate our medical management departments and functions, including behavioral health, pharmacy management, medical economics and operations. Our program includes strategies and activities to address the needs of our members across the healthcare continuum. Program components include:

- Wellness and prevention.
- Catastrophic Case Management.
- Disease management.
- Community Care Management teams.
- Rapid Response Outreach team.
- Community Outreach Solutions.
- Programs to target members overusing and / or abusing services.
- Discharge planning.
- Transition planning.

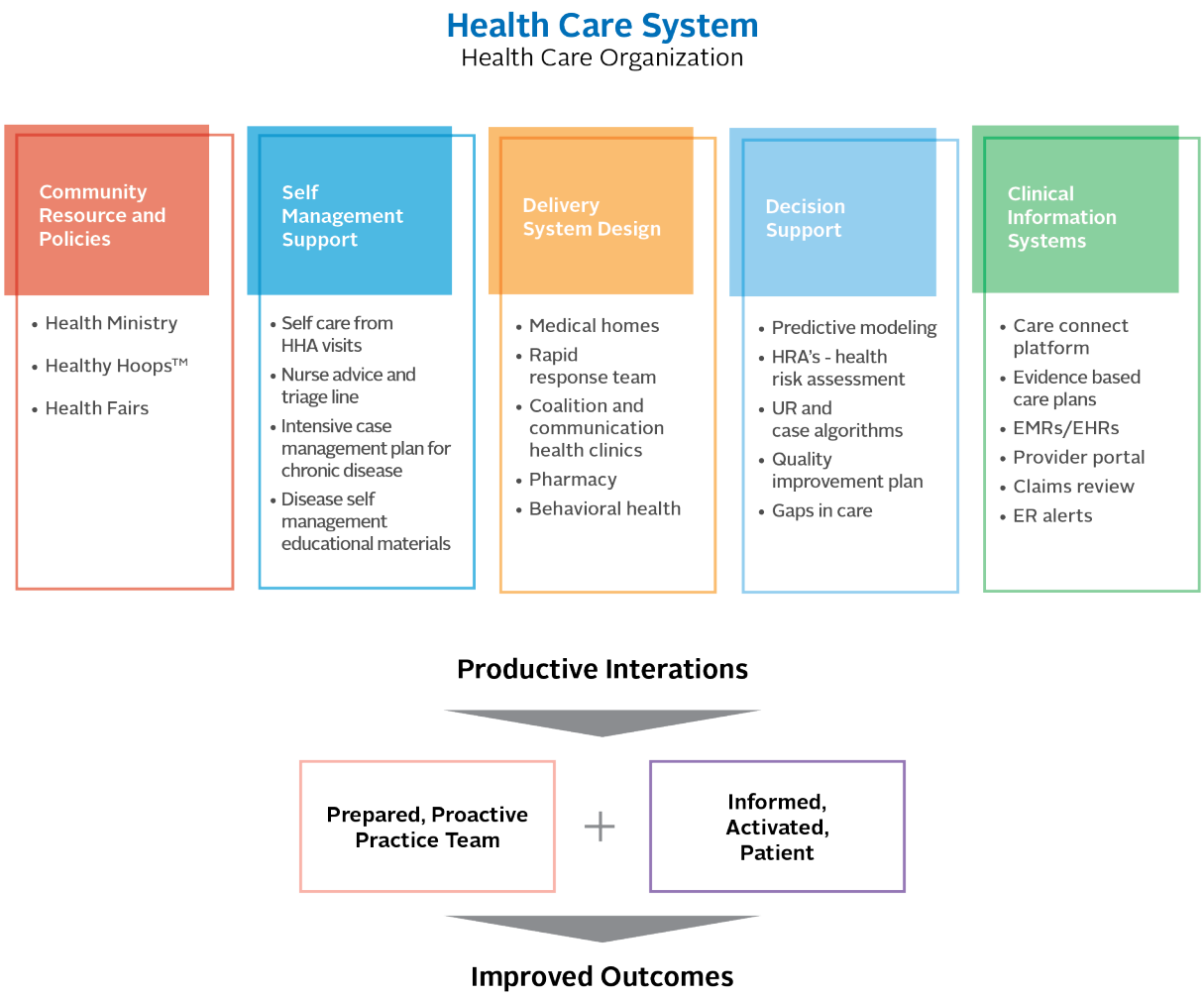

Exhibit 9.1.3-A: AmeriHealth Caritas' Integrated Healthcare Management Program

Members are selected for components of the program using a combination of data mining, event monitoring and information gleaned from individual provider and member interactions. Available medical, behavioral health and pharmacy claim data are analyzed to identify conditions and utilization patterns, and are run through predictive modeling algorithms to identify members at risk for future avoidable episodes of care. Information from member events, such as Admission-Discharge-Transition data from ERs and selection of a new PCP, are monitored to trigger specific care management interventions. Information from provider and member requests for assistance create additional opportunities to identify care management needs.

Members are assigned to wellness, low-risk or high-risk levels based on the outcome of the above activities. The member's risk group may change as new data becomes available, or based on information gleaned through utilization management, provider interactions or member contact.

Members whose needs are primarily wellness and preventive care receive preventive health reminders. These members also have access to access to the 24/7 Nurse Call Line and on-demand care management services through the Rapid Response team.

Members with controlled chronic conditions and short-term needs are assigned to the low-risk group. The low-risk group receives disease management education and monitoring, access to the 24/7 Nurse Call Line and on-demand care management services through the RROT.

AmeriHealth Caritas employs a wide menu of chronic disease management and wellness programmatic support, including diabetes care, chronic asthma management, HIV, coronary artery disease, congestive heart failure, sickle cell disease management, pregnancy and well-child care. Algorithms to address each of these areas are embedded within the care manager's workflow, as indicated for each member enrolled in a care management program.

Members identified as a potential candidate for the high-risk group or long-term support services are contacted for a case management assessment by the AmeriHealth Caritas Iowa care manager who works with the member and caregivers to develop an individualized plan of care.

Discharge planning and transition support occur across all population strata, beginning with the initial contact between AmeriHealth Caritas Iowa and the hospital when the member is admitted. On-site care managers provide additional assistance and contact points for members in high-volume facilities. Post-discharge follow-ups ensure a successful transition is coordinated through the RROT and COS staff.

Wellness and prevention

Our approach to wellness and prevention encompasses screening, immunizations and related care for pediatric members; support, education and prenatal care reminders for pregnant women; general health and wellness reminders focused on healthy nutrition and activity and supportive programs for tobacco use cessation.

Pediatric preventive healthcare

The Pediatric Preventive Health Care (PPHC) program is designed to improve the health of members under age 21 by increasing adherence to EPSDT program guidelines. We accomplish this by identifying and coordinating preventive services for these members. The PPHC combines scheduled written and telephonic outreach with state-of-the art informatics that provides point-of-contact notification of EPSDT needs to associates and providers.

Bright Start

The Bright Start maternity program is managed by a dedicated team of care managers and care connectors. The Bright Start team outreaches to pregnant members and engages them into the program based on internal and external assessments that stratify them into high- and low-risk categories. Care managers coordinate care and address various issues throughout the member's pregnancy and post-partum period, including dental and depression screenings. Members assessed as low-risk receive information via mailings with access to a care manager as necessary. Members identified as high-risk are managed by the plan with a team of both care managers and care connectors.

Healthy nutrition and activity

To support healthy nutrition and activity in our members, AmeriHealth Caritas Iowa will offer free memberships with participating YMCA organizations and free Weight Watchers® memberships for members looking to attain a healthy weight. As needed, care managers will arrange for nutrition counseling sessions for members in need of additional support and guidance.

All of our member materials reinforce simple steps a member can take to improve their health. Nutrition choices and activity levels play a prominent role in that effort. We also offer a selection of health-promotion community education sessions, delivered at local community venues. Topics are focused on

specific age groups and include 25 Ways to Wellness; Healthy You, Healthy Me (weight management); Healthy Heart; Healthy Tips for Teens; Stay Strong, Live Healthy; and Manly Tips for Healthy Living.

Tobacco use cessation

AmeriHealth Caritas Iowa will provide coverage of counseling sessions to help members quit using tobacco products. In addition to seventy counseling sessions per calendar year, AmeriHealth Caritas Iowa will cover a range of tobacco cessation medications. Counseling sessions may be provided in either group or individual counseling formats. Members do not need a referral or pre-approval to go to a counseling session, but they will receive encouragement and support from the RROT to find the counseling services that fit them best. The Provider network will also be educated on AmeriHealth Caritas Iowa's tobacco cessation benefits and local/state-wide resources.

Wellness and Prevention	
Selection criteria	• Open to all members. • Specific outreach topics based on age and gender according to EPSDT and preventive health guidelines. • Pregnant members identified using pregnancy-related category of aid, data mining (claims with a pregnancy diagnosis or for pregnancy-specific services such as obstetrical ultrasound), self-identification or provider notification. • Tobacco use is identified through data collection during the initial health screen, as well as during more in-depth case management assessments.
Strategies	***General*** • CARE Card is a customizable member incentive program where member earns incentive dollars on a re-loadable debit card by completing age/gender-specific preventive health services. • Sponsor/facilitate community education events featuring health and wellness services, such as preventive dental screenings, lead screening and blood pressure monitoring. • Community education programs delivered to community groups and faith-based organizations highlighting health topics. • Care gap identifications programmed for a variety of preventive health services appear as alerts on the Provider Web Portal and AmeriHealth Caritas Iowa staff screens. • Care gap reports, available at the practice level, provide physician offices with information on missing preventive health services for their members. ***Additional strategies for pediatric preventive care*** • Birthday cards including reminders for recommended EPSDT services and developmental milestones associated with the child's age. • Outreach calls to the parent/guardian to remind of recommended immunizations and screenings and assist in appointment scheduling. • Data mining to identify members who are missing recommended services. • Focused outreach from RROT care connectors to assess for barriers and facilitate appointments. • EPSDT service summary attached to the pediatric MCS in the secure Provider Web Portal lists immunizations and screening services with date received. • Care gap alerts, returned when a provider office checks eligibility through the NaviNet Provider Web Portal, notify providers of needed services at the point of care. ***Additional strategies for Bright Start*** • Providers receive an extra payment for submitting an ONAF at the time of the member's first prenatal visit. • Member can earn CARE Card incentive dollars for obtaining prenatal care in the first

Wellness and Prevention	
	trimester, attending 85 percent of recommended prenatal care visits and attending a post-partum visit in the recommended post-delivery timeframe. ***Additional strategies for healthy nutrition and activity*** • Enhanced benefits for YMCA and Weight Watchers memberships. • Community-based education programs to promote healthy nutrition and activity levels. ***Additional strategies for tobacco use cessation*** • Active referrals to the QUITLINE IOWA Program. • Assistance for the Member and PCP to complete forms necessary to participate in QUITLINE IOWA • Assistance connecting to tobacco cessation counseling services

Exhibit 9.1.3-B: AmeriHealth Caritas' Wellness and Prevention Approach

Catastrophic case management:

Members are identified for assessment for Catastrophic Case Management (CCM) services based on the results of data mining, referrals from providers, assessment triggers encountered during utilization management activities and requests from members or caregivers. Identified members are enrolled in the CCM arm of our program. These members receive comprehensive and disease-specific assessments and reassessments, along with the development of short-term and long-term goals and an individualized care plan, created with input from the member/caregiver and the physician(s). In addition to their care plans, Members in this category receive additional assistance with managing their care. For example, some may receive assistance making appointments and arranging transportation to attend their appointments with Providers. Others may need face-to-face care management from Community Care Management teams (CCMTs) or field care management staff.

The CCM team contains registered nurse care managers and non-clinical care connectors. Under the direct supervision of the care manager, non-clinical care connectors assist the member with various interventions. Care managers coordinate care and address various issues, including but not limited to, pharmacy, durable medical equipment (DME), dental access, assistance with transportation, identification of and access to specialists, and referral and coordination with behavioral health providers and other community resources. The care manager also refers members meeting LTSS trigger criteria for an LTSS assessment and assists with coordinating services that are outside the core benefits of the plan.

Catastrophic Case Management	
Selection criteria	***Data mining*** • Members with dominant chronic conditions[1] (e.g., heart failure, diabetes, serious mental illness, chronic obstructive pulmonary disease, chronic kidney disease) or asthma and potentially preventable events.[2] • Frequent ER or inpatient admissions (< 30 days apart). • High-risk diagnoses (e.g., failure to thrive, transplant candidacy). • Special needs Children (Down's syndrome, cleft lip/palate, genetic disorders, cardiac disorders, sickle cell disease). • Multiple prescriptions and/or multiple prescription drug prescribers. ***Utilization Management Triggers*** • Mental health or substance abuse admission. • Requests for in-home supportive care. • Requests for behavioral health services (e.g., applied behavioral analysis for autism, behavioral health rehabilitation services). • Catastrophic situations (e.g., burns, motor vehicle accident, trauma). • Antenatal complications. ***Assessment findings*** • Multiple co-morbid conditions with an unstable support system. • Dependency for basic care needs (e.g., bathing, eating, shelter).

1 AmeriHealth Caritas Iowa licenses 3M Clinical Risk Grouper (CRG) as the risk-adjustment tool and clinically-based classification system to identify members with dominant chronic conditions (DCCs), which are serious lifelong conditions that usually result in progressive deterioration of one's health. The underlying categorical clinical model for 3M CRGs is applicable to all types of episodes and across all potential configurations of episodes (window lengths, included resources, etc.). It considers all of the diagnoses, procedure and prescription medications coded in the member's medical and pharmacy claims collected longitudinally, along with recent time period and frequency of services, as well as demographics information, such as age and gender to assign each individual to a single, mutually exclusive risk group.

2 AmeriHealth Caritas Iowa uses 3M Potentially Preventable suite of products to identify potentially preventable events (PPEs), including potentially preventable admissions (PPAs), potentially preventable readmissions (PPRs), potentially preventable ER visits (PPV) and potentially preventable ancillary services (PPSs). For PPRs, 3M uses comprehensive software solutions that include global and clinical exclusions to determine the patients at risk and identify 30-day readmissions that are clinically related to the initial admission. PPAs, PPVs and PPSs are expressed as a list of clinical conditions, although PPVs following a hospitalization may require additional exclusions. PPAs are expressed as a list of all patient refined Diagnosis-related groups (APR) DRGs and PPVs and PPSs are expressed as a list of enhanced ambulatory patient groups (EAPGs). APR DRGs and EAPGs are used to risk adjust the services and are comprehensive method of determining a patient's reason for admission or ambulatory visit and severity of illness. APR DRGs expand upon DRGs by also assigning to each case a severity of illness (SOI) subclass and risk of mortality (ROM) subclass. EAPGs classifies and consolidates services across the full range of ambulatory settings including same day surgery units, hospital emergency rooms, and outpatient clinics based on procedure codes, presence of Evaluation & Management (E&M) codes and diagnoses codes

Catastrophic Case Management	
Strategies	• Motivational interviewing, used by all care management staff to assist member/caregiver to identify person-centered goals and initiate steps to meet the goal. • Integrated care management platform facilitates aggregation of all data related to the member in one view and data sharing with the PCP and other providers and community agencies involved in the member's care. • Holistic assessment and planning process includes a focus on social determinants of health. • Person-centered focus facilitates engagement and maximizes self-management skills. • Fully-integrated behavioral health and pharmacy capability eliminates fragmentation, including routine assessment for behavioral health co-morbidities and drug therapy management evaluations. • Community-based extensions of the care management team (e.g., COS team, CCMT) deliver care management interventions where the member is, improving engagement rates and persistence. • Blended disease management approach integrates disease-state education and monitoring into the plan of care for all members receiving complex care management services. • Care manager expertise drawing on a wide variety of clinical and educational backgrounds, including social work, nursing, and behavioral health and medical subspecialties.

Exhibit 9.1.3-C: AmeriHealth Caritas' Catastrophic Case Management Approach

Community Care Management teams

Members who fit the classification of "super utilizer," based on a history of or a risk for a disproportionate utilization of services and cost, are targeted for engagement by a Community Care Management Team (CCMT), where geographically available. The CCMT provides a high-touch, face-to-face engagement through a community-based team of nurses, social workers and community health workers to help members navigate and increase their access to needed medical, behavioral health and social services. The team also supports the development of member self-management skills through encouragement and coaching for chronic disease management. In addition to improving the care and health outcomes of members, this community-based team provides valuable information for and coordination with other health plan staff and services, as well as other providers in the community.

In rural locations, where the concentration of members does not support a full team, members will still have opportunity for face-to-face interventions using the local COS team for home based assessment and member engagement, linking members to the appropriately licensed telephonic care manager (registered nurse or case manager).

Community Care Management	

Selection criteria	• Analysis of medical and behavioral health claim data to identify members with any of the following:
	  ○ 10 or more ER admissions in the year.
	  ○ Four or more hospital admissions in the year.
	  ○ Two or more hospital admissions in six months.
	• Referrals from AmeriHealth Caritas Iowa Care Management staff or PCPs identifying members who have additional needs beyond those that can be met by the current ambulatory care system and are difficult to engage through telephonic outreach.

Community Care Management	

Strategies	• Home and community-based face-to-face engagement and ongoing visits to build a trusted personal relationship, using trauma informed/sanctuary model of care and doing whatever it takes to support the member toward better health
	• Assessment techniques aimed at identifying unmet needs, understanding the members goals and categorizing the barriers present that keep the member from managing their condition and accessing indicated resources and care, including.
	  ○ Individual interview.
	  ○ Home environmental assessment, including medication in the home.
	  ○ Assessing the presence and effectiveness of the care team assisting the member.
	• Establishing a plan that is aligned and prioritized with member goals and coordinated with the member's care team, which may include medical and behavioral health providers, pharmacists, health plan care managers and community-based organizations that support education, utilities, housing and food. Medication confusion is often evident and the team works closely to understand what medication has been prescribed, to get it in the home and to enhance member's adherence.
	• Work is organized into the following pathways:
	  ○ Behavioral health pathways — Harm reduction, connect or coordinate with providers, drug and alcohol support services.
	  ○ Medical Pathways — Connect and coordinate access to PCP, specialist, pharmacy services. This often includes transportation and navigational assistance.
	  ○ Medication pathways — Assessment, medication reconciliation and ongoing support for adherence.
	  ○ Social service pathways — Connect and coordinate with necessary services to include, but not limited to, child assistance, food, housing, transportation, legal, clothing, utilities, employment and education.
	  ○ Self-management support pathways — Chronic disease management, exercise, risk behaviors, red flags, diet and blood glucose monitoring.
	  ○ Biometric monitoring — Weight, glucose readings, heart rate and blood pressure.
	  ○ Care Gaps — Address unmet preventive or chronic care quality gaps.
	• Members graduate from this program when they are effectively connected to a care team that can support ongoing care management. In some cases, this may include a different level of care. It often takes months of regular face-to-face interaction and many small steps to reach this goal.

Exhibit 9.1.3-D: AmeriHealth Caritas' Community Care Management Approach

Disease state education

AmeriHealth Caritas uses a blended ICM model that combines case and disease management into a holistic approach. An algorithmic "blueprint" is developed for each targeted condition. The blueprint outlines the population management approach and metrics used to manage that condition. Each blueprint includes the following sections:

- Importance — The relevance of the condition to the membership.
- Clinical guideline — The guideline on which the program is based.

- Program goals — Specific goals related to the condition.
- Outcome measures — Specific metrics used to evaluate the program's success.
- Stratification — Logic used to stratify members into low- and high-risk groups.
- Interventions — Program interventions by stratification level.
- Priority interventions — Focused interventions for inclusion in all care plans and assessments.
- Educational materials/resources — Materials available for associates to use in providing disease-state education.
- Innovations — Synergistic initiatives that support the program goals.
- Provider connection — Method for involving provider in the program.
- Internal education — List of internal education programs for associates.
- External education — List of member and provider education related to program goals.
- Reporting — List of dates program updates and evaluation provided for review.

A comprehensive evaluation of each disease management program is conducted annually as part of the IHM program evaluation.

We use the following considerations to identify disease states to target in our Chronic Care/Disease Management program:

- Incidence of the identified disease state in the population.
- Ability of evidence-based healthcare to improve the health state of the affected member.
- Availability of current professional standards, supported by scientific evidence and research.
- AmeriHealth Caritas Iowa will implement Chronic Care/Disease Management programs for the following conditions during the first year of the contract: Diabetes, asthma, cardiovascular disease, depression and obesity.

Disease Management	
Selection criteria	• **Data mining** — Identification of members with targeted conditions using claim diagnoses and condition-related medications (where possible, industry-accepted algorithms are utilized). • **Provider referrals** — identifying members with a newly diagnosed condition. • **Member self-identification** — Through contact with an AmeriHealth Caritas Iowa call center indicating the presence of a targeted condition (e.g., a request from a member on where to obtain a glucometer).

Disease Management	
Strategies	• **Care gap identification**: — Programmed for a variety of condition monitoring algorithms, which appear as alerts on the Provider Web Portal and AmeriHealth Caritas Iowa staff screens. • **Care gap reports** — Available at the practice level for provide physician offices with information on missing condition-related services for their members. • **Member education** — Easy-to-understand, culturally relevant materials designed to educate the member on the disease process and simple steps for managing the condition. • **Care gap outreach** — Reminder calls to educate on recommended condition monitoring services, such as HgbA1c monitoring for members with diabetes, and assist with appointment scheduling and transportation arrangements. • **Individual coaching** — For members managing multiple conditions who need additional support and assistance navigating needed healthcare and community services. • **Community education programs** — Delivered at local community sites that address condition-related topics, including diabetes and asthma management. • **Coordination with available community resources** — Additional support for member needs, including food pantries that supply fresh produce and utility assistance to ensure refrigeration for insulin.

Exhibit 9.1.3-E: AmeriHealth Caritas' Disease Management Approach

Rapid Response and Community Outreach teams

An important component of the IHM model, the RROT was developed to address the urgent needs of our members and to support our providers and their staff. The RROT team consists of registered nurses, social workers and non-clinical care connectors.

There are three key service functions performed in the RROT unit:

- **Inbound call service** — Members and AmeriHealth Caritas providers may request RROT support via a direct, toll-free Rapid Response line. Referrals to RROT will also be received through many sources, including customer services, pharmacy services, utilization review, and provider services. The RROT toll-free number will be provided as a contact point for all member mailings and automated messaging, encouraging members who need additional support or information to call. The number will also be publicized to providers through provider newsletters, provider orientation and interactions between the network account executives and the provider through our "Let us Know" program. Let us Know is a campaign designed to encourage physician offices seeing our members to reach out to us for assistance supporting the member's needs, whether the needs are related to healthcare follow up, such as starting a new medication or coordination of other support services, such as food pantries or utility grants.
- **Outreach service** — Outreach activities include telephonic contact to address care gaps and support special projects or quality initiatives, such as a fall flu vaccination campaign. RROT associates also initiate follow-up calls to members recently discharged from the hospital and members who contacted the 24/7 Nurse Call Line the previous day to assist those members to reconnect with their PCP office.
- **Care management support** — Care connectors support care managers by completing tasks and reminder calls in support of the individualized plan of care. These include appointment scheduling and

reminders, transportation support, member educational mailings and other administrative tasks assigned by care managers.

Care managers are also part of the RROT and provide care management services for members with urgent health concerns that are clinical in nature. Calls are triaged by the care connector, who involves the care manager when indicated by the urgent needs assessment or clinical situation.

Rapid response associates are trained to assist members in investigating and overcoming the barriers to achieving their healthcare goals. Staff can address questions concerning how to obtain medications, supplies or medical equipment, offer assistance in finding a PCP or specialist physician or how to get help with making physician appointments. Both care managers and care connectors are well informed of available community services and are available to assist with the application process and follow-through until service delivery.

Rapid Response and Outreach	
Selection criteria	• Available to all members through a toll-free phone number.
Strategies	• **Make every contact count** — Medicaid recipients are often difficult to contact. Addressing member issues and probing for additional needs while the member is on the phone fosters trust and enhances the member's willingness to engage in self-management activities. • **Let us Know** —Providing physician offices with an easy-to-access mechanism to get assistance managing their patients once the patient leaves the office provides critical follow-up, as well as reduces the fear some physicians have about their ability to meet the needs of Medicaid recipients. • **Outbound contact campaigns** — Use of an autodialer so the time care connectors spend speaking with members is maximized and not wasted dialing the phone.

Exhibit 9.1.3-F: AmeriHealth Caritas' Rapid Response and Outreach Approach

Avoiding Readmission

Sofía is a 62 year-old Spanish-speaking female diagnosed with metastatic cervical cancer. A bilingual RROT care connector contacted Sofía the next day to review her discharge instructions, verify that her home healthcare was in place, that she had a follow-up medical appointment and to identify any barriers to following her plan of care.

Sofía's daughter was providing some of her care. The daughter indicated that Sofía had her new pain medication, that the home health nurse had visited and established a visit schedule and that the wound care supplies were delivered. However, the daughter was in need of irrigation syringes and a drainage bag for her mother's care. The care connector contacted the equipment company to arrange for the missing supplies and marked Sofía's case for a follow-up call to check on the supplies and Sofía's pain control.

During the follow-up call, the care connector uncovered that the additional supplies had not arrived. After several unsuccessful calls to the equipment vendor, the care connector arranged for the home health nurse to deliver the supplies.

Community Outreach Solutions

As an integral component of the IHM model, the COS team extends core components of the IHM program in the community. COS team members are hired from and stationed in communities across the AmeriHealth Caritas service area. The COS team provides two key functions:

- Community engagement — COS team members form relationships with community organizations in their assigned territory to facilitate awareness of services and programs available to AmeriHealth Caritas members. Through these relationships, the COS team identifies opportunities for partnerships, including education for organization staff on how to contact us to access services for a member and delivery of community education programs at the organization's site.
- In-person care management follow-up — COS team members provide face-to-face follow-up with high risk members at the request of other members of the AmeriHealth Caritas IHM teams to confirm connections and identify barriers to ambulatory care. These in-person interactions provide opportunities to identify and address barriers and member needs, as well as reinforce services available through AmeriHealth Caritas Iowa's care coordination program.

Community Outreach Solutions	
Selection criteria	• Members identified through care management interactions that need additional in-person support and follow-up. • High-risk members who the care management team is unable to reach via telephonic outreach. • High-risk members who are discharged from the hospital.
Strategies	• Community care connectors are hired from the communities they serve, providing innate knowledge of community norms and concerns. • Face-to-face interactions engender a higher degree of trust than telephonic encounters. • Community care connectors wear brightly colored apparel carrying the AmeriHealth Caritas Iowa logo (and carry AmeriHealth Caritas Iowa picture identification) to identify themselves to community representatives.

Exhibit 9.1.3-G: AmeriHealth Caritas' Community Outreach Approach

24/7 Nurse Call Line

Our 24/7 Nurse Call Line provides members with access to symptom counseling and healthcare guidance by a registered nurse. This is particularly helpful for a rural population, as clinical counseling is made available at all times to any member with access to a telephone. A summary of the member's interaction with the 24/7 Nurse Call Line is faxed to the Rapid Response team and the PCP. Our RROT care connectors subsequently contact the member to assess any additional needs and to help reconnect the member with the PCP, if appropriate.

24/7 Nurse Call Line	
Selection criteria	Available to all members through a toll-free phone line.
Strategies	Providing easy access to a registered nurse who can provide basic health education and symptom counseling gives members who are unsure if they are experiencing an emergency an alternative to an emergency room visit.

Exhibit 9.1.3-H: AmeriHealth Caritas' Nurse Call Line Overview

Programs to target members overusing and/or abusing services:

AmeriHealth Caritas monitors utilization patterns at the member level to identify members overusing and/or abusing services. Our approach encompasses specific initiatives for members who are receiving multiple prescriptions (polypharmacy), receiving controlled substance medication prescriptions from multiple prescribers and/or pharmacies, members whose utilization patterns don't match their age/gender profile or medical history, and members with frequent emergency room visits.

Polypharmacy — Drug therapy management

Members receiving 10 or more prescription medications, receiving multiple oral hypoglycemic or antipsychotic medications and children receiving psychotropic medications are referred to our drug therapy management (DTM) program for a comprehensive clinical and pharmacy review. Pharmacists and pharmacy technicians review integrated data (e.g., pharmacy, medical, lab, vision, dental), identify gaps in therapy and proactively address any identified issues though personalized consultations with patients and prescribers. All information on the review, recommendations and actions taken is recorded in the member's record in our population health management system. Care management staff follow-up with the member (or parent/guardian in the case of a child) to ensure understanding of any changes to therapy.

Controlled substance prescriptions

For members prescribed controlled substances, AmeriHealth Caritas Iowa will monitor refill patterns, number of prescribing physicians and number of pharmacies filling the prescription. Members receiving multiple prescriptions from different physicians and/or filled by different pharmacies are flagged for a care management assessment. Information on the member's prescription patterns is communicated to the prescribing physicians, to ensure that the member is receiving a coordinated treatment approach. Where permissible, we will restrict the member to receiving controlled substance prescriptions from one physician and one pharmacy.

Depending on the member's needs and goals, we will assist the member to locate appropriate substance use counseling. Suspicious activity, on the part of the member or physician, is referred to the AmeriHealth Caritas Iowa Special Investigations Unit (SIU) for further evaluation.

Mismatched utilization

Through ongoing data analysis, AmeriHealth Caritas Iowa will monitor for members whose claim history does not match their age/gender/medical history profile, as this may indicate lending of the AmeriHealth Caritas Iowa identification card to other individuals. Examples include claims for a well visit and prostate-specific-antigen lab test for a 38 year old woman, or a claim for a left foot bunionectomy for a member with a left below-the-knee amputation. Results from the data analysis are reviewed by the SIU, with further evaluation and action taken as appropriate.

In addition, all AmeriHealth Caritas Iowa staff receives training on identifying potential abuse and the mechanism to forward those cases to the SIU for investigation.

Frequent ER utilization

Members with frequent visits to the ER are flagged for outreach, assessment and education by the RROT. Based on the frequency of emergency room visits and the information gathered from the member's clinical and behavioral health history, outreach may occur via an educational mailing (used for members with 2 visits), phone outreach, education and individual care management support (as warranted for members with 3 or more visits) or referral for in-person care management (for members with multiple visits and unstable support systems).

Educational components of this program include information on emergency room alternatives (24/7 Nurse Call Line, telemedicine visits), locations of urgent care centers and information on availability of other PCP locations, including health homes for members who don't feel their needs can be met with their current PCP

Over Use and Abuse of Services	
Selection criteria	***Drug therapy management*** • Members receiving prescriptions for 10 or more medications. • Members receiving multiple oral hypoglycemic or antipsychotic medications. • Children prescribed psychotropic medications. ***Controlled substance review*** • Members receiving more than one controlled substance medication per month. • Members receiving controlled substance prescriptions from more than one physician. ***Utilization mismatch*** • Members with claims for services that are not consistent with the member's age, gender or previous medical history ***Frequent ER utilization*** • Members with more than 2 emergency room visits in a 90-day period. Additional outreach strategies employed for members with higher levels of ER utilization
Strategies	***Drug therapy management*** • Clinical review of medical, behavioral health claim history and medication regimen by a pharmacist or pharmacy technician. • Discussion of pharmacist recommendations between the pharmacist and the physician. • Discussion of member opportunities between the member and the care manager. ***Controlled substance review*** • Referral for complex care management assessment and intervention, including person-centered care. • Where permissible, restriction of the member to one prescribing physician and/or pharmacy. ***Utilization mismatch*** • Data analysis and referral to SIU for investigation and action. ***Frequent ER utilization*** • Educational outreach on appropriate use of the ER and urgent care alternatives, including 24/7 Nurse Call Line, telemedicine visits and urgent care centers. • Individual assessment and barrier identification with ongoing care management as warranted. • In-person engagement and support as part of an ongoing care management plan.

Exhibit 9.1.3-I: AmeriHealth Caritas' Overuse and Abuse of Services Approach

Discharge Planning

AmeriHealth Caritas recognizes that effective discharge planning and follow-up plays an important role in helping members avert potentially preventable events and avoidable readmissions. We have developed a formal discharge program that engages key stakeholders while the member is still in the hospital to identify and coordinate the member's post-discharge care needs. AmeriHealth Caritas coordinates with facility discharge planners, the hospitalist caring for the member in the hospital, and the member's PCP and needed post-discharge care providers to develop a comprehensive discharge plan.

AmeriHealth Caritas is also exploring options to embed Acute Care Transition (ACT) care managers in high-volume facilities and primary care practices. We have successfully used this model in our other markets. The embedded care manager works directly with the member and the provider staff to coordinate additional services, initiate follow-up for treatment plan changes and provide direct member education in support of treatment.

Hospital discharge planners, PCPs and specialists are encouraged to contact AmeriHealth Caritas' UM department for assistance with member discharge. Phone numbers are identified in the Provider Handbook specifically for discharge notification and discharge planning. In addition to notices of admission, AmeriHealth Caritas monitors prior authorization and claims data to identify when one of our members has been admitted to an acute-care setting. Our UM nurses perform ongoing, concurrent reviews of the care admitted members receive, as well as outreach to admitted members. Using the diagnosis, length of stay and reported social supports, AmeriHealth Caritas identifies the member's potential discharge care needs, the level of follow-up and care coordination needed from AmeriHealth Caritas.

The discharge plan details all planned medical, behavioral and home healthcare services, including transportation and other community supports that the member will need after leaving the hospital. Follow-up appointments are also outlined so that the member's PCP can continue to monitor the member's health during the transition period. AmeriHealth Caritas communicates with the member's providers throughout this transition to coordinate prior authorization requests, referrals and medication regimens.

UM associates then coordinate with the hospital discharge planners, attending physician, hospitalists and appropriate ancillary service providers, to assist in coordinating necessary arrangements for post-discharge care needs. This may include working with the member's support network to ensure that needed home equipment and post-hospitalization services are in place when the member arrives home. This includes coverage and authorizations for any needed home healthcare services, prescription or over-the-counter medications, durable medical equipment, medical supplies and/or community supports.

AmeriHealth Caritas encourages home healthcare as an important support for members who are discharging from the hospital. The UM department helps coordinate medically necessary home health and home infusion needs with the member's PCP, attending specialist, and the selected home health provider. The member's first six home health visits do not have to be authorized; however, additional visits would require prior authorization.

Behavioral health admissions

For members admitted for inpatient behavioral healthcare, additional discharge planning efforts focus on ensuring that the member transitions to outpatient follow-up care within a seven day period. To facilitate those transitions, AmeriHealth Caritas Iowa will seek to mirror programs in other our affiliate markets where outpatient behavioral healthcare visits begin the day of discharge or are facilitated through home behavioral health visits.

- In all of our affiliate markets, discharge planning from behavioral health inpatient admissions begins upon admission. Our clinical care reviewers ask about aftercare information at every review. We provide information to the inpatient provider regarding other providers involved with the member, supports that AmeriHealth Caritas provides, such as Rapid Response and Catastrophic Care Management, as well as their responsibility in scheduling aftercare appointments for the member within seven days of discharge.

- In Indiana and Washington, D.C. affiliates, AmeriHealth Caritas contracted with multiple home-based mental health providers to provide the behavioral health-related outpatient aftercare appointments in the comfort of the member's home. In Indiana, these initiatives have resulted in increasing the HEDIS Follow-Up after Hospitalization for Mental Illness (FUH) rate from 20 percent to 60 percent over a four-year period.
- In Indiana, bridge appointments were added to the fee schedule. Bridge appointments, occurring on the day of member discharge, ensures that the member understands the aftercare plan, identifies and resolves any barriers to member adherence to the aftercare plan. Bridge appointment providers link the member back to their behavioral health outpatient provider and the plan's IHM team.
- In Washington, D.C., AmeriHealth Caritas has contracted with the McClendon Center, community-based mental health center in downtown Washington, D.C. for adults diagnosed with serious and persistent mental illnesses (SPMI). In the McClendon pilot program, our affiliate, AmeriHealth Caritas District of Columbia, notifies the McClendon Center of a member's admission to any psychiatric inpatient unit within the District of Columbia. A patient discharge coordinator (PDC) from the center meets with the member within one day, and remains in contact through phone and every other day visits until discharge. Upon discharge, the PDC accompanies the member to the first outpatient therapy visit.
- AmeriHealth Caritas Iowa also recognizes that psychiatrist availability in some parts of the state may be limited. As such, we will leverage telepsychiatry services to augment provider availability for timely follow up visits.

Lauren is a 14-year-old girl with a diagnosis of reactive airway disorder (RAD), triggered by viral infections and extreme activity. Lauren was subsequently diagnosed with major depression after a reported sexual assault. After initially participating in outpatient therapy, Lauren stopped taking her medications and attempted suicide in January. She resumed outpatient therapy and was restarted on medication. A few months later, she again attempted to end her life by a drug overdose.

To assist Lauren and her mother successfully navigate the transition home process and connect her with additional outpatient therapy, the AmeriHealth Caritas care manager aligned with the facility arranged to meet with Lauren and her family before a scheduled family planning session with Lauren. The care manager gathered assessment information; answered questions related to the authorization process and allayed concerns the family had about costs associated with Lauren's care. The care manager explained several components of the transition home process available to Lauren, including the availability of a behavioral health clinician to visit Lauren and the family in their home within seven days of Lauren's discharge. Lauren's family was extremely grateful for the times that the care manager spent with them and pleased that the care manager would continue to be available to them for follow up after Lauren returned home.

Lauren was discharged and is receiving outpatient therapy. The AmeriHealth Caritas care manager is working with Lauren's mother to arrange an evaluation for an Individualized Education Plan (IEP) with the school to address Lauren's poor grades and difficulty paying attention while performing school work.

Members receiving LTSS

All members approved for or receiving LTSS are contacted by their assigned care manager within the first day of the hospitalization to initiate discussions on the discharge planning process. For members who are

medically unstable, the initial contact may be with the member's appointed representative. At the appropriate time during the hospitalization, the care manager meets in person with the member and available family/caregivers to identify changes needed in the member's community support infrastructure and develop plans to address those needs. This may include arranging for additional equipment in the home, a different level of transportation, or additional direct care support.

Transition success

Jay is a 44-year-old male who became eligible for Medicaid following a massive stroke. He had no prior medical coverage and had a feeding tube, tracheostomy and multiple medications at the time of discharge. The AmeriHealth Caritas care manager assisted his family in coordinating skilled nursing and home health aide visits so he could return home. They also arranged for ambulance transportation to physician appointments after discharge and worked closely with his provider prior to discharge to discuss his ongoing needs.

After speaking with our care manager, his provider agreed to complete a home visit to follow up, evaluate and coordinate his care. Our care manager also referred Jay to a community agency to evaluate his needs and determine what type of services would be beneficial. As a result of this referral, his sisters have been designated as his primary caregivers and are being paid by the community agency to provide personal care services. With these supports, Jay has successfully been cared for in his home since discharge.

Discharge Planning	

Selection criteria	• Members admitted to inpatient facilities.
	• High-risk criteria:
	  ○ Admitted for inpatient behavioral healthcare.
	  ○ Admitted with a condition related to a dominant chronic condition (DCC) or asthma.
	  ○ Readmitted following a previous discharge.
	  ○ Admitted with a pregnancy complication.
	  ○ Receiving or eligible for LTSS.

Strategies	• Ongoing contact with inpatient facilities to ensure they have AmeriHealth Caritas Iowa contact information or Provider Web Portal access to report admissions and initiate discharge planning • ACT care managers stationed at high-volume facilities interact with the member, family and treating providers to plan for services and support needed for ongoing care needs. • AmeriHealth Caritas Iowa utilization management staff work closely with facility reviewers and discharge planners to identify available supports and ongoing care needs, make arrangements to initiate services upon discharge and enter any needed authorizations, and schedule a follow-up physician appointment. • Authorization requirements for the first six home health visits are waived. • Outpatient follow-up visit appointments are made prior to the member leaving the hospital. • For high-risk and LTSS members, the member is contacted during the inpatient stay to identify needs and plan appropriate post-discharge care and support.

Exhibit 9.1.3-J: AmeriHealth Caritas' Discharge Planning Approach

Transition planning

AmeriHealth Caritas uses a variety of monitoring and outreach methods to follow members post-discharge. Recently discharged members are a priority population for our Rapid Response team. We also use in-person outreach and Care Management teams to follow-up with recently discharged members in their communities.

RROT associates perform additional critical roles throughout the discharge planning process to prepare for the transition. Upon receipt of a referral from UM upon member admission to an inpatient facility, an RROT associate refers the member to a care manager, mails several notification letters, including a "notification of inpatient admission" letter to the member's PCP, a transition letter to the member and a "hospital care manager notification" letter to the behavioral health inpatient facility where the member was admitted so they are aware of the care manager's name. The RROT associates then investigate to determine whether the member lives in an area where the plan can arrange a home visit.

After the member transitions out of the acute-care setting, AmeriHealth Caritas care managers or Rapid Response associates call the member to assess the member's understanding of their discharge plan and determine whether appropriate services are being received. This includes medication reconciliation and understanding of the medication regimen, as well as assistance scheduling any needed non-emergency medical transportation. If home health was not ordered upon discharge, but the post-discharge outreach indicates it may be beneficial, AmeriHealth Caritas works with the member to identify a local home health provider and then contact the member's provider to initiate a referral.

When possible, high-risk members receive additional in-person follow up from community-based care managers or COS associates. COS and care management staff will be stationed across the state to facilitate in-person follow-up with members in the high-risk category. The focus of these face-to-face encounters is to assess understanding of the post-discharge treatment instructions, ensure that needed services (such as home healthcare or equipment) are in place and working satisfactorily, facilitate review of prescribed medications and identify any barriers to keeping scheduled follow-up appointments.

Behavioral health transitions

Ensuring connections to outpatient behavioral healthcare is a critical component of post-discharge follow-up for members discharged after a behavioral health admission. In addition to developing mechanisms to connect the member to outpatient services prior to leaving the facility, AmeriHealth Caritas care managers follow all members discharged from a behavioral health inpatient setting for a minimum of 60 days to encourage attendance at outpatient therapy appointments. AmeriHealth Caritas Iowa will ensure that the member's PCP is aware of the discharge summary and aftercare appointments to enable collaboration between physical health and behavioral health providers.

Our care manager will use available resources as clinically indicated. These resources include network providers, peer supports, community outreach specialists, community health workers, community agency supports and the member's natural support system. As needed, the care manager will arrange for a peer support specialist or community care connector to accompany the member to the first outpatient appointment. The focus of the transition is to provide sufficient supports to the member to be safely maintained in their community.

Members receiving LTSS

All members approved for or receiving LTSS receive a home visit from a care manager on the day of discharge. During the visit, the care manager reviews discharge instructions and verifies the member's and caregiver's understanding of symptoms to report and reconciles medications, so that the member and

caregiver are clear on which medications the member needs and when. The care manager also verifies the date, time and transportation arrangements for the member's next physician visit. This initial home visit is followed by two to three subsequent home visits by members of the care team during the next seven days. These visits are used to verify that all aspects of the plan of care are functioning, and gauge member and caregiver stress level and ability to maintain the needed level of services. As needed, the care manager will work with the member's PCP to order additional hours or levels of support.

Additional support and planning, discussed in Section 4, occurs for LTSS members who wish to transition from a residential facility back to the community.

Transition Management	
Selection criteria	• Members admitted to inpatient facilities • Additional support for high-risk and LTSS members and members discharged following a behavioral health admission
Strategies	• Follow-up contact after discharge focused on evidence-based tenets: ○ Member/caregiver understanding of discharge instructions ○ Member/caregiver understanding of symptoms to report to the physician ○ Medication reconciliation/availability ○ Follow-up appointment scheduled; transportation available • Home visits for high-risk and LTSS members • Peer Support services for members discharged from a behavioral health admission

Exhibit 9.1.3-K: AmeriHealth Caritas' Transition Management Approach

Avoiding readmission

Carol is a 60-year-old with a history of heart failure, COPD, diabetes, hypertension, gastro esophageal reflux, coronary artery disease, gait imbalance due to an old ankle fracture and two cardiac stents. Carol was discharged from the hospital after being admitted with chest pain. The RROT care connector contacted Carol the next day to review her discharge instructions, verify that she had her medications and a follow-up PCP appointment, and identify any barriers to following her plan of care.

During routine probing, Carol identified that she did not have her glucometer anymore. The care connector arranged for delivery of a new glucometer to be delivered and marked Carol's case for a follow-up call to check on the glucometer and the upcoming PCP appointment. During the follow-up call, the care connector verified that the glucometer arrived.

In conversation with Carol about the upcoming PCP appointment, Carol identified that she was not sure she could get to the doctor's office due to her inability to walk meaningful distances. The care connector initiated the process to connect Carol to the county transportation service, making multiple phone calls to the PCP office, Carol and the transportation provider to get the paperwork completed prior to Carol's appointment.

2. Provide data on outcomes achieved in your care coordination programs operated in other states, if applicable.

AmeriHealth Caritas has demonstrated strong care coordination outcomes across the states in which we operate. We believe a focus on care coordination is essential to helping members achieve the best possible

outcomes, both in terms of health and lifestyle. We track outcomes across several domains, including clinical guideline adherence, appropriate utilization, member reported wellness, and member and provider satisfaction. Results of our overall integrated healthcare management program were independently evaluated by the Milliman, Inc. The evaluation showed that we achieved a 4.3 percent reduction over the expected cost trend, which we estimate to amount to over $20 million in savings for our Indiana affiliate's Aged-Blind-Disabled (ABD) population. We recently looked at the impact of our integrated healthcare management program in our South Carolina affiliate and observed a 40 percent decrease in inpatient admissions for individuals enrolled in the program, statistically significantly greater than the experience of a control group of non-enrolled members. Over 95 percent of members enrolled in AmeriHealth Caritas care management programs are "Satisfied" or "Very Satisfied" with their care manager and the services received during the program. They are more likely to engage in primary care services and receive recommended care.

Improved health outcomes

Looking at data from AmeriHealth Caritas' longest running health plan, Keystone First, members engaged with an AmeriHealth Caritas care manager have higher completion rates for preventive and condition-specific care than that of plan membership as a whole.

	Total Plan	Engaged Members	% Difference
Women's health			
Breast cancer screening (BCS)	66.19%	78.93%	19.25%
Cervical cancer screening (CCS)	70.95%	87.50%	23.33%
Cardiovascular disease			
Controlling high blood pressure (CBP)	60.44%	70.59%	16.79%
Persistence of beta blocker after a heart attack (PBH)	94.74%	100.00%	5.55%
LDL-C screening performed	79.20%	92.31%	16.55%
LDL-C control (<100 mg/dL)	43.14%	57.69%	33.73%
Comprehensive diabetes care (CDC)			
Hemoglobin A1c (HbA1c) testing	82.51%	87.50%	6.05%
HbA1c poor control (>9.0%)	36.72%	34.38%	-6.37%*
HbA1c control (<7.0%)	39.23%	42.86%	9.25%
Eye exam (retinal) performed	51.67%	59.38%	14.92%
Medical attention for nephropathy	80.92%	90.63%	12.00%
**Lower results are better for this measure*			

	Total Plan	Engaged Members	% Difference
Use of appropriate medications for people with asthma (ASM)			
Total	**86.91%**	**95.05%**	**9.37%**
Adult access to preventative/ambulatory health services (AAP)			
Total	**85.57%**	**99.08%**	**15.79%**
COPD management			
Use of spirometry testing in the assessment and diagnosis of COPD (SPR)	25.82%	30.36%	17.58%
Pharmacotherapy management of COPD exacerbation (PCE)			
Systemic corticosteroid	78.30%	83.33%	6.42%
Bronchodilator	91.39%	97.37%	6.54%

Exhibit 9.1.3-L: AmeriHealth Caritas' Keystone First Outcomes Overview

Appropriate utilization

Bending the curve for "super utilizers"

Members with chronic medical conditions and behavioral health comorbidities that fall into the highest segment of inpatient and emergency room utilization pose a special challenge to health plans. These members often have challenges forming productive relationships with the traditional healthcare delivery system, and the delivery system is often not able to adequately address the members' multiple complex needs. AmeriHealth Caritas uses community care management teams to form one-on-one engagement relationships with the member and assist the member to connect to a custom support web. The typical member has four to five admissions in a six-month period, little to no engagement with a PCP or health home, three or more chronic medical conditions and at least one behavioral health condition. There are currently four Community Care Management Teams operating in AmeriHealth Caritas plans across the country. The results for these programs demonstrate statically significant reductions in utilization and medical costs, driven primarily by reductions in inpatient utilization. As expected, slight increases were seen in outpatient utilization and prescription drug costs.

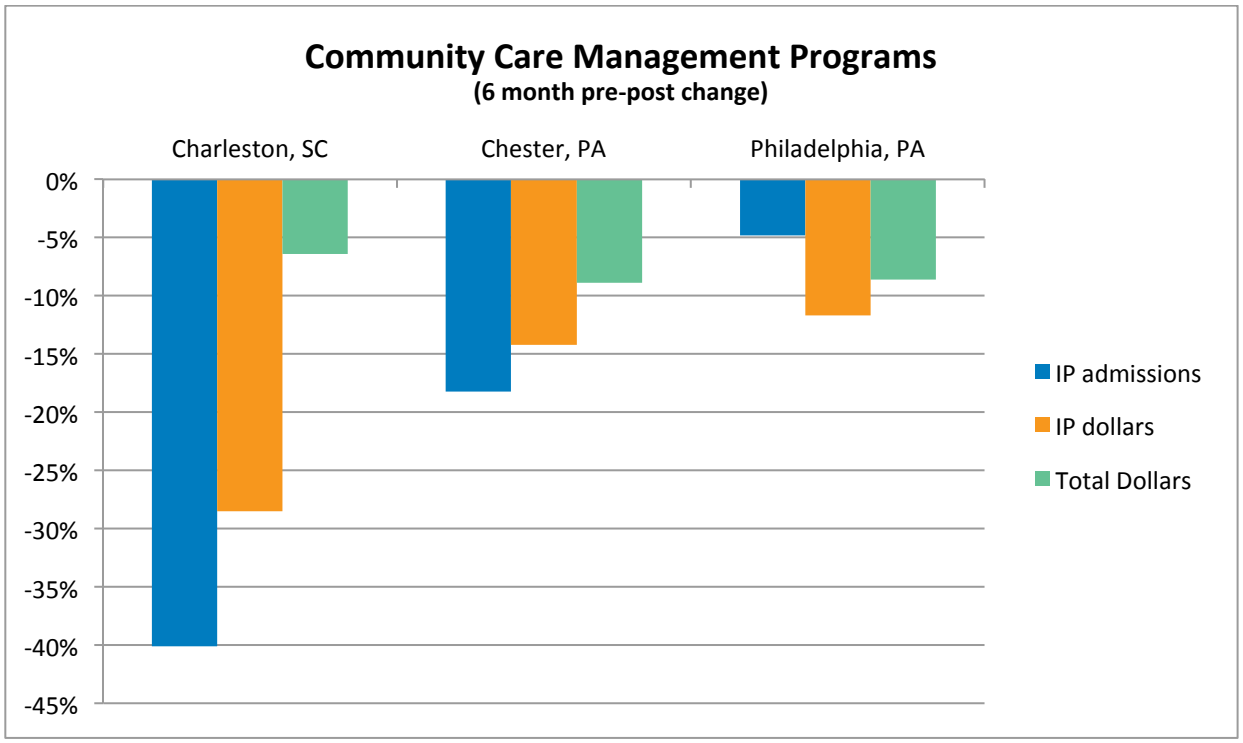

Exhibit 9.1.3-M: AmeriHealth Caritas' "Super Utilizers" Outcomes

Medication Adherence

Medication non-adherence is a primary cause of suboptimal chronic disease management. During 2013, AmeriHealth Caritas undertook an enterprise effort to incorporate education and refill reminder efforts in our care coordination programs to improve adherence for members prescribed asthma controller medications, hypoglycemics, statins and/or antihypertensives. Using a cohort approach, members prescribed the target medications who had a baseline Proportion of Days Covered between 20 percent and 66.7 percent (the corporate average) and also had a valid Proportion of Days Covered in the measurement year, were include in the study. Proportion of Days Covered, which measures the number of days in the period for which medication was dispensed, was used as a proxy for medication adherence. A patient was included in the adherence measure calculation if they had received at least two fills of medication during the period measured to account for potential therapy discontinuation.

Medication Class	Percent Change in Proportion of Days Covered
Antihypertensive	24.1%
Asthma controller	5.2%
Hypoglycemic	22.4%
Statins	25.5%

Exhibit 9.1.3-N: Example Medication Adherence Outcomes

Additional analysis is underway to quantify the impact of these results to utilization and medical costs. Preliminary analysis indicates that members with asthma prescribed an asthma controller medication saw

the greatest reductions in inpatient admissions and total medical costs. To further support these efforts, AmeriHealth Caritas is adding prescription refill reminders to our mobile application.

Optimizing utilization and cost

Ongoing analysis for members involved with AmeriHealth Caritas' Integrated Care Management model demonstrates reductions in overall costs and costs related to inpatient care.

Population	Market	Results
Members engaged through care managers embedded in Primary Care Practices3	Southeastern Pennsylvania	• 23% decrease in emergency room visits. • 21% decrease in emergency room costs. • 33% decrease in inpatient admissions. • 26% decrease in inpatient costs.
Members engaged in telephonic care management4	Central Pennsylvania	• 36% decrease in emergency room visits. • 27% decrease in emergency room costs. • 30% decrease in inpatient costs. • Comparisons for this group to a risk-adjusted cohort showed statistically significant decreases (p<.0001) in ER and inpatient cost and utilization.
Members engaged in telephonic care management[1]	Southeastern Pennsylvania	• 32% Decrease in emergency room visits. • 231% Decrease in emergency room costs. • 41% decrease in inpatient costs. • Comparisons for this group to a risk-adjusted cohort showed statistically significant decreases (p<.0001) in ER and inpatient cost and utilization.
SSI Members engaged in telephonic care management5	South Carolina	• 19% decrease in emergency room costs. • 48% decrease in inpatient costs. • 40% decrease in inpatient admissions. • Comparison for this group to a risk-adjusted cohort showed statistically significant decreases (p<.0001) in inpatient admissions and costs and emergency room visits.
SSI Members engaged in telephonic care management with behavioral and physical health comorbidities	South Carolina	• 19% decrease in emergency room costs. • 8% decrease in emergency room visits. • 48% decrease in inpatient costs. • 40% decrease in inpatient admissions. • Comparison for this group to a risk-adjusted cohort showed statistically significant decreases (p<.0001) in inpatient admissions and costs and emergency room costs.

3 KF CY 2013 compared to CY 2012
4 ACPA CY 2013 compared to CY 2012
5 SHSC May 2013 through April 2014 with at least 6 months engagement

Population	Market	Results
Super utilizer members engaged through Community Care Management teams[4]	Charleston, South Carolina	• 45% decrease in inpatient costs • 45% decrease in inpatient admissions • 18% decrease in total claim costs
Super utilizer members engaged through Community Care Management teams6	Chester, Pennsylvania	• 22% decrease in inpatient costs • 25% decrease in inpatient admissions • 6% decrease in total claim costs
Super utilizer members engaged through Community Care Management teams7	Philadelphia, Pennsylvania	• 11% decrease in inpatient costs • 4% decrease in inpatient admissions • 8% decrease in total claim costs

Exhibit 9.1.3-O: Overview of Utilization and Cost Outcomes across AmeriHealth Caritas

Reducing potentially preventable events (PPEs)

AmeriHealth Caritas monitors potentially preventable events (PPEs) as an indicator of opportunity to improve member connections with care. PPEs include:

- **Potentially preventable initial admissions (PPA)** — Avoidable hospitalizations based on conditions that are determined to be ambulatory care sensitive. Adequate patient monitoring and follow-up can often avoid the need for admission.
- **Potentially preventable ER visits (PPV)** — May result from a lack of adequate access to care or ambulatory care coordination.
- **Potentially preventable ancillary services (PPS)** — High cost imaging, minor cardiac and vascular tests, and certain lab tests that may not provide useful information for diagnosis and treatment.
- **Potentially preventable readmissions (PPR)** — Return hospitalizations within a 30-day readmission time interval that are clinically-related to a previous hospital admission.

PPEs are used both as a trigger for a care management evaluation in members with chronic conditions, and as a metric to evaluate the effectiveness of care management engagement. AmeriHealth Caritas health plans experienced the below results for members with dominant chronic conditions (according to the 3M methodology) who had high levels of PPEs:

Market	Results
Southeastern Pennsylvania	36% decrease in PPEs, driven by a 46% decrease in PPAs
Central Pennsylvania	46% decrease in PPEs, driven by a 65% decrease in PPAs
Louisiana	37% decrease in PPEs, driven by a 52% decrease in PPAs
South Carolina	40% decrease in PPEs, driven by a 653% decrease in PPAs
Indiana	50% decrease in PPEs, driven by a 76% decrease in PPAs

6 12 month pre vs post; claims incurred through 9/30/14.
7 6 month pre vs post; claims incurred through 9/30/14.

Market	Results
Nebraska	48% decrease in PPEs, driven by a 69% decrease in PPAs
District of Columbia	57% decrease in PPEs, driven by a 63% decrease in PPAs

Exhibit 9.1.3-P: Overview of PPE Outcomes across AmeriHealth Caritas

Reducing readmissions

In evaluating the impact of our program on readmission rates, AmeriHealth Caritas focused on members with at least one dominant chronic condition or the moderate chronic condition of asthma. These members have a 7.5 times higher readmission rate than members without data markers for those conditions. Through extensive redesign of transition management processes and creation of new member education campaigns, AmeriHealth Caritas decreased readmission rates for members in this target population by 10.9 percent from 2013 to 2014. Market-specific data is displayed in the table below.

Readmissions per 1,000 member year				
LOB	**12 Months Ending Nov. 2013**	**12 Months Ending Nov. 2014**	**Absolute Change**	**% Change**
Keystone First	19.39	17.70	-1.69	-8.7%
AmeriHealth Caritas Pennsylvania	8.49	7.60	-0.89	-10.5%
AmeriHealth Caritas Louisiana	13.70	11.28	-2.42	-17.7%
Select Health	9.07	8.34	-0.74	-8.1%
MDwise Hoosier Alliance	3.32	3.30	-0.02	-0.6%
Arbor Health Plan	7.08	5.00	-2.07	-29.3%
OVERALL	**11.83**	**10.47**	**-1.36**	**-11.5%**
Note: AmeriHealth District of Columbia removed due to insufficient historical data (prior to May 2013).				
Current 12 months vs. prior 12 months — claims incurred through Nov. 2014 and paid through Feb. 2015 to allow for 90 days runout.				

Exhibit 9.1.3-Q: Reduction in Readmissions across AmeriHealth Caritas

To further demonstrate the effectiveness of the enhanced discharge protocols, AmeriHealth Caritas analyzed readmission rates by number of successful contacts. Successful contacts are defined as outbound Care Management, Rapid Response or UM calls where the care manager speaks directly to the member. Successful follow-up calls led statistically significantly lower 30-day readmission rates. Compared with no successful follow-up calls, the odds of readmission were reduced by:

- 22 percent for one contact — OR=0.78; 95 percent CI (0.71-0.86).
- 27 percent for two contacts — OR=0.73; 95 percent CI (0.64-0.83).
- 46 percent for three or more contacts — OR=0.54; 95 percent CI (0.48-0.62).

Member-reported wellness

Member perception of their health and wellness is measured using the 12-item Short Form (SF-12) licensed through Optum™. Members receiving complex care management services are assessed during the initial engagement phase, and then every six to 12 months they are in the program. Analysis of the results identifies improvement in the members' assessment of their general health. Results below depict improved ratings of health and wellness by members engaged in the complex care management program throughout six AmeriHealth Caritas plans in 2014. Members reported improvements in all aspects measured by the assessment tool, with the greatest improvements seen in their overall assessment of their health, energy level and feeling calm and peaceful, as well as less interference of pain, feelings of being downhearted or depressed.

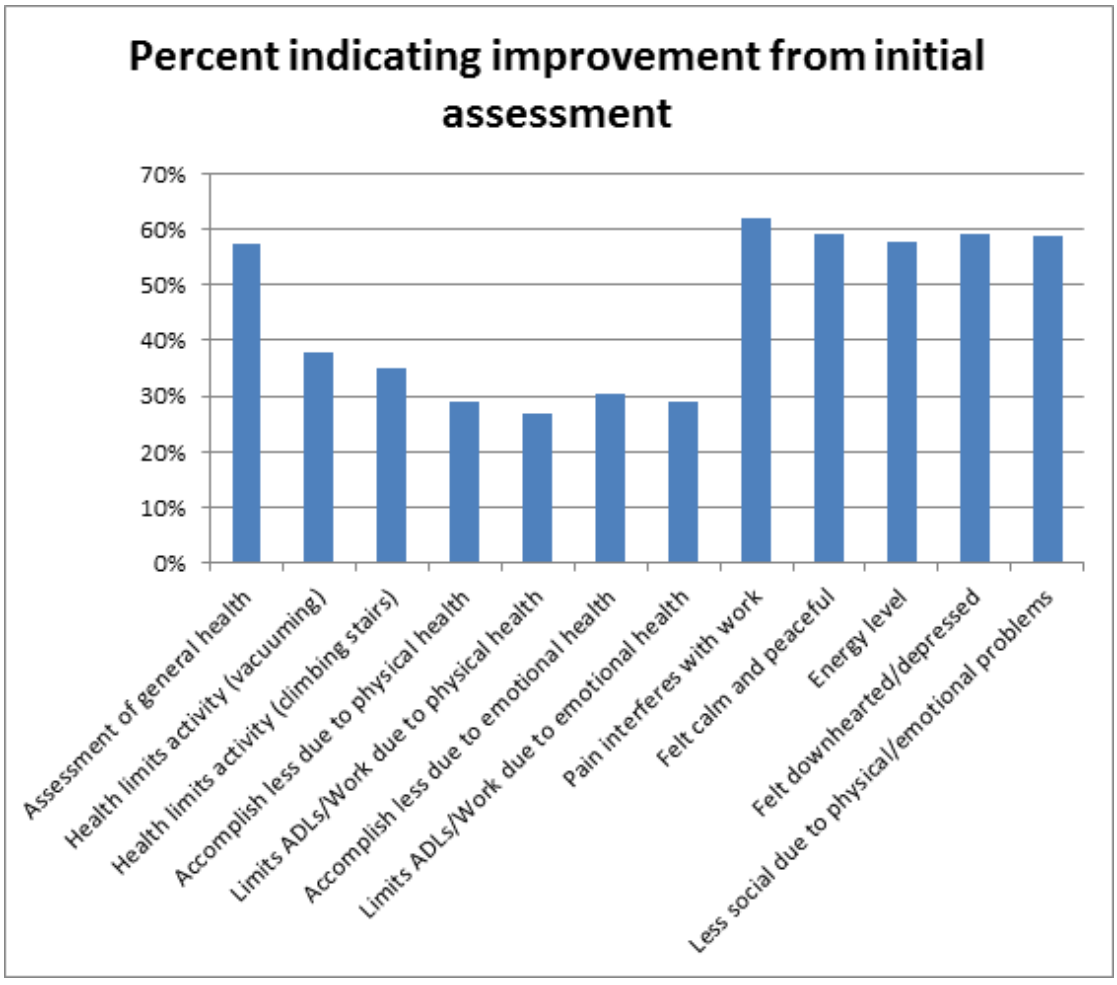

Exhibit 9.1.3-R: Overview of Member-reported Improvement

Member satisfaction

AmeriHealth Caritas also measures satisfaction with its Care Management programs through a formal satisfaction survey process. Surveys are administered by The Meyers Group using a phone interview to collect the member's perception of complex care management and disease-specific program services. Across all plans, members continue to report satisfaction with the interactions and assistance provided by the care management team, increasing their understanding of their condition and quality of life. They also give high marks to the helpfulness of AmeriHealth Caritas' written materials.

Formal results for AmeriHealth Caritas' four largest health plans for surveys conducted in 2014 are summarized below.

Members engaged in Complex Care Management

Composites/Attributes		KF	ACP	LA	SC	Average
Understanding of condition	Extremely or very helpful	84.2%	83.8%	86.1%	92.5%	86.7%
Written materials	Extremely or very helpful	80.0%	82.0%	96.4%	84.6%	85.8%
Quality of life	Greatly or somewhat improved	82.6%	85.3%	83.3%	90.8%	85.5%
Overall satisfaction	Excellent or good/very good	77.6%	74.4%	80.5%	86.4%	79.7%

Exhibit 9.1.3-S: Complex Care Management Member Survey Overall Results

Members receiving condition-specific Services

Diabetes		KF	ACP	LA	SC	Average
Helpfulness of DM care manager	High (8–10)	88%	87%	81%	94%	87.8%
Written materials	Extremely/very easy to understand	83%	93%	91%	93%	89.9%
Satisfaction with program	Excellent or very good	89%	87%	78%	96%	87.5%
Asthma						
Helpfulness of DM care manager	High (8–10)	94%	87%	81%	97%	89.6%
Written materials	Extremely/very easy to understand	82%	79%	91%	96%	86.8%
Satisfaction with program	Excellent or very good	86%	87%	78%	94%	86.2%

COPD						
Helpfulness of DM care manager	High (8–10)	91%	86%	N/A	N/A	88.6%
Written materials	Extremely/very easy to understand	83%	81%	N/A	N/A	81.9%
Satisfaction with program	Excellent or very good	82%	97%	N/A	N/A	89.5%
Heart Failure						
Helpfulness of DM care manager	High (8–10)	88%	60%	N/A	N/A	74.0%
Written materials	Extremely/very easy to understand	73%	100%	N/A	N/A	86.4%
Satisfaction with program	Excellent or very good	87%	88%	N/A	N/A	87.1%

N/A — Not Assessed: Due to small volume of members with a primary disease focus of heart failure or COPD in these specific plan populations, separate metrics were not assessed.

Note: KF = Keystone First, ACP = AmeriHealth Caritas Pennsylvania, LA = AmeriHealth Caritas Louisiana, SC = Select Health of South Carolina; DM = disease management

Exhibit 9.1.3-T: Complex Care Management Member Survey Condition-Specific Results

9.1.4 Risk Stratification

1. Describe your proposed risk stratification methodology.

AmeriHealth Caritas Iowa's risk stratification methodology will combine data analysis with assessment findings to assign the member to a wellness, low-risk or high-risk group.

Clinical risk groups

AmeriHealth Caritas Iowa's risk stratification will inform the intensity and frequency of follow-up care that is required for each member participating in the Care Coordination program. Our approach focuses on identifying members whose clinical diagnoses and utilization demonstrate patterns that suggest that the members are unable to manage their conditions on their own. To identify this population, we utilize the 3M risk adjustment and patient classification methodologies to assist us in identifying a target population. Our target population goes beyond the sickest members, including those that have serious chronic conditions that could lead to progressive health deterioration, making them future high utilizers of healthcare services. In our experience, this population benefits significantly from care management programs.

To complete the analysis, we will utilize the 3M Clinical Risk Grouper (CRG), a risk-adjustment tool and clinically-based classification system used to measure a population's burden of illness. 3M CRGs uses

AmeriHealth Caritas' standard medical and pharmacy claims collected longitudinally to assign each individual to a single, mutually exclusive risk group. The underlying categorical clinical model for 3M CRGs is applicable to all types of episodes, creating a uniform and stable clinical language. Across all potential configurations of episodes (window lengths, included resources, etc.), the episode clinical model remains unchanged. 3M CRGs relate the historical clinical and demographic characteristics of the individual to the amount and type of healthcare resources that the individual will consume in the future.

Since the 3M CRGs are clinically-based, rather than a regression risk-adjustment model, they create a language that links the clinical and financial aspects of care. This "language" is easily understood by clinicians and therefore actionable. 3M CRGs provide a comprehensive and clinically specific classification for a full range of populations.

Our strategy in utilizing the 3M CRG methodology is to focus on members with dominant chronic condition, moderate chronic condition of asthma, or pregnancy. Dominant chronic conditions are serious lifelong conditions that often result in progressive deterioration of an individual's health if untreated, including conditions such as heart failure, diabetes and chronic obstructive pulmonary disease.

Potentially preventable events

In addition to focusing on members who have the above conditions we also further concentrate on members who have the highest potentially preventable utilization.

PPEs include avoidable hospital admissions and readmissions, unnecessary emergency room visits, unnecessary ancillary services and hospital-acquired complications. AmeriHealth Caritas currently monitors the following PPEs:

- **Potentially preventable initial admissions (PPA)** — Avoidable hospitalizations based on conditions that are determined to be ambulatory care sensitive. Adequate patient monitoring and follow-up can often avoid the need for admission.
- **Potentially preventable ER visits (PPV)** — May result from a lack of adequate access to care or ambulatory care coordination.
- **Potentially preventable ancillary services (PPS)** — High cost imaging, minor cardiac and vascular tests, and certain lab tests that may not provide useful information for diagnosis and treatment.
- **Potentially preventable readmissions (PPR)** — Return hospitalizations within a 30-day readmission time interval that are clinically-related to a previous hospital admission.

Additional data mining techniques

Additional data sets that factor into our stratification methodology include Logical Observation Identifiers Names and Codes (LOINC®), DTM algorithms and care gap algorithms. Commonly found in laboratory billing data, LOINC data facilitate the exchange of clinical results, such as maternal risk conditions. Reports based on maternity-related LOINC are used to identify pregnant women who may have a change in their pregnancy risk status, which will trigger a care management re-assessment by the Bright Start maternity management team. DTM algorithms identify members receiving multiple medications where there may be an opportunity to streamline the medication regimen and improve adherence. Care gap algorithms identify members who are not receiving recommended care related to preventive care and chronic condition management guidelines.

Stratification

Using the results of the above data analysis, an initial stratification is completed based on the presence of PPEs, chronic conditions, pregnancy status and unmet care needs. Members with high levels of PPEs are prioritized for additional outreach and assessment. Members are also identified for in-depth care management assessments through referrals from providers, identification of risks during utilization management, rapid response encounters and member self-identification.

Results of information gathered during the assessment process are used in conjunction with available data analysis results, to place the member in the appropriate risk group. Additional segmentation is performed using a four-quadrant model based on the level of behavioral health versus physical health needs.

2. Describe your proposed risk stratification levels.

Members are assigned to one of three risk levels based on available claim and assessment data: Wellness, low risk or high risk. All LTSS members, whether approved for LTSS or on a waiting list, are assigned to our high-risk level cohort.

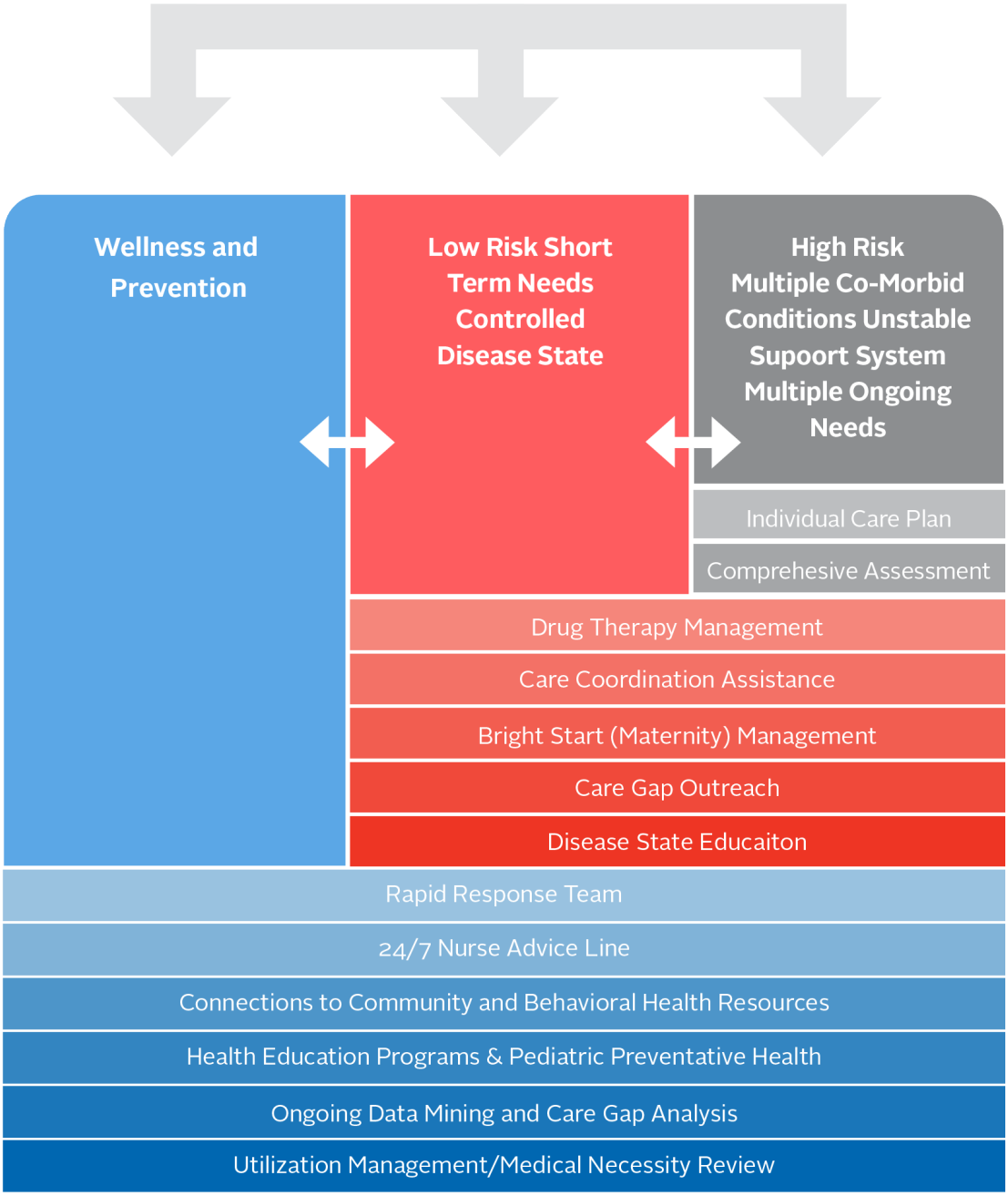

Exhibit 9.1.4-A: Overview of AmeriHealth Caritas Iowa Risk Stratification

We modify the member's risk group assignment as new data becomes available, or based on information gleaned through utilization management, provider interactions or member contact. For example, a member who has well controlled type 2 diabetes mellitus may be initially grouped in the low risk category, but through the care manager contact, social barriers to care are identified and the member is moved to the high-risk category. This movement is especially fluid for members in the high-risk level who may need to be evaluated for long-term support services due to changes in their health or changes in the health or availability of their informal caregiver supports.

- **Wellness and Prevention** — Members that currently do not have a chronic condition are assigned to this group. These members typically need reminders for preventive health services and education related to activities related to health promotion.
- **Low Risk** — Members with controlled chronic conditions and short-term needs are assigned to the low-risk group. These members benefit from education on their condition, reminders for health monitoring and medication refills, and assistance coordinating treatment and follow-up care. They typically have capacity for self-management and may also benefit from additional support and connection to community resources.
- **High Risk** — High risk members are those that have multiple co-morbid conditions, have catastrophic events, unstable support system, social instability and / or multiple ongoing needs, such as transition of care or inpatient episodes with discharge planning. These members need assistance navigating and connecting with needed healthcare services, as well as help identifying and connecting with available community supports. They usually need coaching to strengthen their self-management skills or may not be capable of self-management.

High-risk members are further classified based on their level of physical health and behavioral health needs. This classification provides guidance in the identification of the best team member to take the lead on the member's care management team:

- **Level I** — Members with low behavioral health and low physical health needs will be managed through the Episodic Care Management team.
- **Level II** — Members with high behavioral health and low physical health needs will be managed by a behavioral health specialist.
- **Level III** — Members with low behavioral health and high physical health needs will be managed by a registered nurse (RN).
- **Level IV** — Members with high behavioral health and high physical health needs will be managed by an RN with strong behavioral health experience.

3. Describe how care would be managed for members in each risk stratification level.

Wellness and Prevention — Members in this group receive preventative health reminders and health education programs to continue wellness and prevention activities. They have access to the 24/7 Nurse Call Line and on-demand care management services through the Rapid Response team. These members are monitored through data mining, care gap analysis and health risk screens to identify unmet needs or the need to transition the member to a higher risk level.

Low Risk — Members in the low-risk group receive educational materials on their chronic condition(s) and preventive care, access to the 24/7 Nurse Call Line and on-demand care management services through the Rapid Response team. Available biometric data (hgbA1c, LDL-C and blood pressure readings) and medication refill information are added to the data mining and care gap analysis performed for this population. Ongoing monitoring scans for changes in their condition that could move them to high risk.

High Risk — High risk members receive telephonic and face to face interaction from care managers. These members receive a comprehensive assessment, including a focus on social and environmental needs. Assessment information is also collected from family, caregivers and providers involved in the member's care. The care manager works with the member/family to identify preferences and prioritize goals. Based on the agreed upon goals, the care manager develops a care plan designed to capitalize on the member's strengths.

In our risk stratification schema, LTSS members are stratified as high risk and supported by the highest intensity of care and specialized services for members. Intensely focusing resources on this costly, high risk population produces cost savings, improved quality of care and improved quality of life. Examples of LTSS members who would fall in this risk category include:

- Those institutionalized but qualifying for transfer to a home or community setting.
- Members with physical conditions impairing their ability to get care and services away from living environment.
- Members with advanced illness or end of life.
- Those living in a facility based setting.
- Non-institutionalized members who qualify for a nursing facility level of care but who are living in the community.
- Members facing imminent loss of their living situation.
- Members with insufficient caregiver arrangements.
- Members with deteriorating mental or physical conditions.

9.1.5 Member Identification

1. Describe how you will identify members eligible for care coordination programs, including how the following strategies will be utilized

Predictive modeling

AmeriHealth Caritas Iowa's algorithms incorporate analysis of medical, behavioral health and pharmacy claims to identify members belonging to targeted chronic condition populations. We have a robust Medical Economics department that provides reports on high dollar claims in addition to targeted chronic conditions.

AmeriHealth Caritas Iowa focuses on targeting members with unusually high utilization patterns (suggestive of poor disease self-management) who are therefore in need of intervention. To identify this at-risk population, we utilize the 3M CRG risk adjustment and patient classification methodology to assist us in determining the members who would benefit most from care management programs.

AmeriHealth Caritas runs its standard medical and pharmacy claims collected longitudinally through the grouper model to assign each individual to a single risk group. The grouper platform relates the member's historical clinical and demographic characteristics to the quantity and type of healthcare resources that he/she is projected to consume in the future, thereby linking the clinical and financial aspects of care, providing comprehensive and clinically specific classifications for a full range of populations and supporting our provider value-based payment models.

By using this methodology, we are able to focus on members with any dominant chronic condition, moderate chronic condition of asthma, who are pregnant or who have the highest potentially preventable utilization.

PPEs include avoidable hospital admissions and readmissions, unnecessary emergency room visits, unnecessary ancillary services and hospital-acquired complications. AmeriHealth Caritas currently monitors the following PPEs: PPAs, PPVs, PPSs and PPRs.

Focusing on and reducing PPEs leads to improved patient outcomes and lower medical costs, and can be achieved through better coordinated care and first targeting interventions for individuals with multiple chronic conditions . Using this approach, AmeriHealth Caritas reduced readmissions by 11.5 percent across seven Medicaid health plans in 2014.

Claim review

In addition to predictive modeling, we review claim data monthly to identify members who are newly diagnosed with targeted conditions, including diabetes, asthma, depression and hypertension. Identified members are enrolled in our disease management programs.

Claim review is also used to identify members with high utilization patterns, including inpatient and emergency room care. These members are referred for educational outreach, care management assessment and community care management intervention.

Review of pharmacy claims is conducted routinely to identify members with polypharmacy (more than 10 prescription medications). These members are referred for Drug Therapy Management review by a licensed Doctor of Pharmacy and a care manager.

Claim review is also used to identify events that need additional follow-up, such as a new prescription for ADHD medication or a missed refill for an asthma medication. These events trigger an outreach call by the Rapid Response team to coordinate needed services, provide educational reminders and identify/address any barriers to care. LOINC data may indicate a new pregnancy complication, which triggers re-assessment by the Bright Start team.

Member and caregiver requests

Members may also be identified through request either by the member themselves or caregivers by:

- Calling directly into Member Services or RROT.
- Being contacted during outreaches to members through RROT for care gaps,
- Being contacted during our outreaches for care management if a sibling or parent in the family has a need.
- Receiving educational mailings with our contact information.
- Receiving reports from 24/7 Nurse Call for member-initiated after-hours calls followed by referral received by care manager.
- Requesting services through our website.
- Requesting services while they are attending community events.

Provider referrals

Physicians and other providers may refer members into care coordination programs through the Let Us Know program (see above for description and below for examples), by calling directly into Member services or RROT, referrals through our Provider Web Portal or referrals through the account executives.

Member follow-up through "Let us Know"

The PCP office for Luke and Ryan, 8 and 12 year old members who were missing appointments, called to ask for assistance. The RROT care connector reached out to the boys' parent with no response to four outreach calls. The case was forwarded to the COS team. The COS worker went to the parent's address and was able to speak with the boy's mother and connect her to the RROT care connector. The mother explained that she had not taken the children to appointments because she was taking care of her mother who was on dialysis. She allowed the RROT care connector to assist her in scheduling appointments for the well visits of both children. Later, the mother was reminded of the appointment by the care connector. She did attend the appointment and the well visit was completed successfully.

9.1.6 Care Plan Development

1. Describe in detail how person-centered care plans will be developed for each member.

AmeriHealth Caritas uses a person-centered care plan approach where each care plan has two main objectives. The first objective is centered on the member achieving a maximum level of self-management for their health condition(s), and social and environmental needs. The second objective is centered on how the care manager will guide and assist the member to reach self-management goals, and at the same time, educate, assess and move the care plan forward.

All AmeriHealth Caritas Iowa care management staff are trained in cultural sensitivity and preferences, motivational interviewing and strength-based planning. These skills assist the care manager to develop a plan focused on things that are important to the member. Care managers work with the member to select and prioritize goals. They also employ techniques from minimally disruptive medicine research to avoid overwhelming the member and caregiver with multiple tasks and changes at the same time.

The care manager will begin by eliciting the primary concern of the member. The first step for each situation is to identify the member's biggest concern with the member's current health state. That concern may not be related to the issue identified in the member's assessment findings and utilization data. The care manager will ask the member to identify personal goals, as opposed to healthcare goals. By focusing on the member's concerns, like wanting to walk a child to school or go dancing with friends, the care manager can address items like nutrition for healing of a foot wound or proper use of asthma medication. Once plans are in motion to address the member's personal goal, the care manager will work toward addressing additional issues revealed in the assessment findings and utilization data. For each intervention, the care manager will focus the discussion on how the particular intervention will benefit the member.

2. Describe how the care plan development process will be individualized and person-centered.

Our individualized, person-centered care plan empowers the member to take charge of their treatment, choose who is on the treatment team, establish and prioritize goals on the individualized plan of care. The member determines what "success" is for them. To elicit the member's goals, we use open-ended questions and frame questions beyond just the scope of healthcare, asking about things the member would like to see changed. We then assist the member to identify small steps and changes that will move them toward that goal.

We incorporate healthcare elements in the plan in terms of how they will support the member's goal. For example, a member who wishes to spend time playing with her grandchild may identify that she could spend more time if she was less short of breath. This will lead to a discussion of mechanisms to reduce shortness of breath associated with the member's COPD.

We use motivational interviewing techniques to form a collaborative conversation for strengthening a person's own motivation and commitment to change. The goal is to more effectively help members get the care they need when they need it the most. Motivational interviewing is another integrated care management tool that treats the whole person and considers the unique needs of each individual. It focuses on a member's motivation and commitment toward changing unhealthy behavior.

Motivational interviewing is based on collaboration, not confrontation. It is designed to strengthen an individual's motivation for, and movement toward, a specific goal by eliciting and exploring the person's own reasons for change. Our care managers evoke an individual's own thoughts rather than imposing the care manager's ideas. The power for change rests with the member rather than the care manager.

AmeriHealth Caritas conducted intensive, interactive two-day on-site training programs for care managers on how to use motivational interviewing effectively. We also developed a train-the-trainer approach — cultivating clinical trainers and other staff as future motivational interviewing trainers. Feedback has been overwhelmingly positive.

So far, more than 300 Care Management associates in Pennsylvania, South Carolina, Louisiana, District of Columbia and Indiana have completed motivational interviewing training and training continues to expand.

As an example, early in 2014 our associate Chris was serving as an integrated care manager for Select Health. He worked with Jane, a member with poorly managed diabetes, to schedule her diabetes follow-up appointments. Having completed motivational interviewing training, Chris used reflective listening and open-ended questions to further explore Jane's concerns with visiting her primary care doctor to address her uncontrolled diabetes.

"Jane was using the word 'uncomfortable' when discussing how she felt leaving her house to go to the doctor," Chris said. "I used the stronger word 'afraid.' After a brief pause, Jane agreed she was fearful of leaving her home, but also concerned she was not seeing her doctor. She acknowledged behavioral health problems were her biggest barrier to care."

Rather than offer unsolicited advice, Chris asked permission to offer advice and suggested Jane make counseling her top priority. Jane agreed. She asked her PCP for a referral and made an appointment to visit a professional counselor.

Jane later asked Chris, without any prompting, why she had protein in her urine and how she could better protect her kidneys. Chris again asked permission to offer advice and helped her understand the consequences of uncontrolled diabetes, the qualities of medications that protect the kidneys and the importance of medication compliance.

"I only used a few of the basic tenets of motivational interviewing and saw immediate results," said Chris, who now is a motivational interviewing trainer in corporate clinical systems. "Our relationship improved. I continued exploring Jane's perceived barriers and advocated the benefits of change — change that offered hope and energy for her future."

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3. Describe how the care plan development process will incorporate findings of the initial health risk screening, comprehensive health risk assessment, medical records and other sources.

The care plan development process incorporates all finding of the initial health risk screening, comprehensive risk assessment, medical records and any other information AmeriHealth Caritas Iowa has incorporated in the member's records. It is important to leverage this prior information in order to build the most informed and personalized care plan. We make this information available through our Jiva care management platform.

The initial health risk screening is stored in Jiva, and this information is readily available and reviewed by the care coordinator prior to contacting the member for the initial care management comprehensive review. This information provides the foundation for the member's initial discussion with the member.

Additionally, Jiva allows the care manager instant access to medical, pharmacy and behavioral health claims data along with inpatient and outpatient authorization information. The system includes information on medication refills, gaps in care, identified conditions and dates of last PCP appointments. Information on inpatient and ER visit information are at the care manager's fingertips. All of this information is reviewed prior to contacting the member. We then have a "picture" of the member's health status when we call or visit the member and can devote our time with the member to uncovering new information and working forward on a plan, versus recapping information that is already known to AmeriHealth Caritas Iowa.

During the comprehensive health risk assessment the care manager collects additional information related to health status and history, functionality, mental health and behavioral health, psychosocial issues, life planning, cultural linguistic, visual and hearing needs, caregiver resources, knowledge of plan benefits and community resources, barriers to care and cognitive function. All of this information is extremely important in understanding the member's needs and strengths.

Our Providers are our partners, and they are a critical component to our ability to improve the overall health and wellness of individuals, families and communities, while at the same time, reduce healthcare costs for individuals and the overall healthcare system. Aided by cutting-edge Theranos technology, we are taking an historic step in transforming how Medicaid Members are able to engage in timely, meaningful discussions with their health care Provider about their overall health and wellness and comprehensive care plans. Theranos' revolutionary lab service platform uses dramatically smaller samples than traditional labs, with samples collected from both capillary draws and traditional methods. Results are returned much faster than industry averages, with the overwhelming majority of results reported within 24 hours of sample collection. We are empowering our Members to fully engage in their healthcare. It is important that our Members and their healthcare Providers have the information they need, when they need it, to develop personal healthcare plans and make healthcare decisions.

Information from the providers involved in the member's care is also collected to provide insight into the members' needs and treatment plan from the provider's perspective. In most cases, the care manager will arrange a time to speak with the physician or clinician involved in the member's care. In some cases, the provider may designate a member of the practice to serve as that communication point.

Using all of the gathered data as a backdrop, the care manager engages the member and, as appropriate the member's family/representatives, in dialogue around the member's goals and aspirations. By starting the care plan process as a means to meet a need identified by the member, the care manager begins to develop a trusting relationship, which is critical to ongoing engagement in the process. The care manager

will ask permission to offer options on activities (based on the needs and strengths identified during the assessment process) that will assist the member in meeting the identified goal(s).

4. Submit a sample care plan for each proposed risk stratification level.

Wellness, prevention and low risk

Care plans for members whose needs are based on reminders for preventive health services, healthy behaviors and basic condition management are generated upon completion of the initial health risk assessment. A sample plan is included within Attachment 9.1.6-A.

Catastrophic care management

Care plans for members receiving individual care management services, including LTSS, are generated by the care management team. The topics addressed in the care plan are prioritized to match the member's goals and preferences. Care is taken not to overwhelm the member by entering large numbers of problems and tasks into the initial plan of care. As one goal is met, additional goals and activities are added. Depending on the capacity of the member and the member's support system, the steps and pace at which the plan can advance may be slow. Progress on health-related goals may be impeded by other social determinants of health and other events in the member's life.

Long-term support services

In addition to the complex care management care plan described above, members eligible for LTSS receive a comprehensive service plan, describe in Section 4 of this response.

Example care plans

See Attachment 9.1.6-A (at the end of this section) for example care plans.

Tracy is a 38-year old woman with heart failure, coronary artery disease, high blood pressure, hyperlipidemia, obesity, lupus anticoagulant with anemia, agoraphobia and anxiety. She has history of multiple (nine) myocardial infarctions and stents, deep vein thrombosis and pulmonary emboli with a Greenfield filter. She takes 14 medications, including an anticoagulant and has a methicillin-resistant Staphylococcus aureus infection on her buttocks. Tracy states that she has a lot of stress in her life and that she helps her 17-year old daughter care for the daughter's eight-month old child. Tracy is easily overwhelmed. She recently stopped smoking. Tracy has a history of non-compliance with specialist and PCP appointments, lab work and diagnostic tests due to her agoraphobia and anxiety.

The care manager began by establishing a rapport with Tracy, slowly helping her through her fears. On several occasions, Tracy was in tears while talking with the care manager, sobbing that she doesn't like living in fear of going out of her house and wants help. The care manager arranged for Quest Diagnostics to do blood draws at the home to foster compliance with the ongoing blood tests necessary to manage Tracy's warfarin (anticoagulant) medication.

The next goal the care manager worked on with Tracy was going to the PCP office. The care manager contacted the office and explained Tracy's fears and potential for anxiety attacks along with ways the office associates could assist to make the visit less threatening for Tracy. The care manager asked the office to keep Tracy in less populated areas of the office, having her wait in an examination room, instead of the waiting room. Arrangements were made for Tracy to have the first appointment of the day, to minimize the number of other patients who would be in the office.

Tracy successfully completed the visit — her first in years. Next, Tracy and the care manager are working on a visit to the specialist.

5. Describe how you will ensure that there is a mechanism for members, their families and/or advocates and caregivers, or others chosen by the member, to be actively involved in the care plan development process.

In order to develop the most effective care plan, AmeriHealth Caritas Iowa believes it is important to encourage the involvement of members, families/caregivers, advocates or others chosen by the member to be actively involved in the care development process. To do this, we work closely with the member to develop the plan in the way that is best for them. We work with the member to understand their preferences in terms of care plan team, care plan development location, and actual goals and steps in the care plan.

First, the member will always be given the option to include whomever they wish when developing the care plan. Next, the plan will offer the option of conducting care plan development either at the member's home or onsite at a provider's office. Finally, the members will be involved in the actual care plan develop by choosing and prioritizing goals. This is a core tenet of our care management process. Plans are much more successful when members have worked closely with the plan development. Lastly, we view care plan development as a conversation across all the parties involved to build plan that best meets the needs of the member and will be supported by the member, along with the member-chosen family members, caregivers, providers and advocates.

6. Describe how you will identify other caseworkers to be included in the care plan process and how services will be coordinated to avoid duplication and/or fragmentation of services.

AmeriHealth Caritas has great experience coordinating other services in the community. AmeriHealth Caritas Iowa is committed to creating a coordinated care plan across caseworkers to help ensure the best outcome for the member. The first step is identifying other caseworkers to be included. AmeriHealth Caritas Iowa uses keywords in Jiva to identify members with community caseworkers. With the member's approval, our goal is to always include the caseworker in the care plan process.

AmeriHealth Caritas works with the member and family/caregiver to identify caseworkers. We also work with other providers / practitioners that are involved in the members care to identify caseworkers. We believe it is important to establish relationships and bi-directional contact points to facilitate communication with other case workers. We will work with other case workers when creating the care plan and share the final plan with other caseworkers. All services the member is receiving and the source of that service will be included on the service plan. This means that there will be one compilation for all care the member is getting and will ensure we do not duplicate services. As appropriate, we will follow-up with other caseworkers as working through the care plan.

Coordinating with other care workers

At the request of a waiver coordinator, the care manager became involved in the case of Christian, a 6-year-old male adopted from foster care, who was born prematurely and had a feeding tube, a tracheotomy

and mental retardation. Christian was receiving home support services through a waiver Monday through Friday, 6:30 a.m. to 3:30 p.m. The mother had also adopted Christian's brother, another special needs child. When the care manager contacted the member's mother, she was in tears. She had been told by the waiver coordinator that the nursing services were being cancelled, although the waiver case worker did not know why and had been unable to resolve the issue.

The AmeriHealth Caritas care manager contacted the agency coordinating the care. When she was unable to make contact, she escalated the issue to the supervisor. Following an investigation into the member's file, the agency determined that at the time of the last review, the case was coded incorrectly, which resulted in a cancellation of the waiver services. The care manager was able to have the services reinstated with no break in coverage.

By working collaboratively with personal care agencies, one of our care managers was able to quickly reinstate medically necessary home services for this 6-year-old boy.

7. Indicate how you will ensure that clinical information and the care plan is shared with the member's PCP (if applicable) or other significant providers.

AmeriHealth Caritas Iowa has several mechanisms available to share clinical information and the member's care plan with the PCP.

Member clinical summary

Through our secure Provider Web Portal, the PCP can access a claim-based MCS, which details the following information:

- Current medications the member filled, including fill date, dosage, prescribing physician name and pharmacy name.
- Clinical conditions associated with the member.
- Inpatient admission information, including date of admission, facility and diagnosis.
- Emergency room visit information, including date of visit, facility and diagnosis.
- Physician visit history, including date of visit, physician name, physician specialty and diagnosis.
- Radiology procedures performed, including date of procedure, procedure description, facility and diagnosis.
- Laboratory results, including date of test, test performed and test result.

For members age 18 and younger, the MCS also includes information on EPSDT services, including:

- Immunization information, including immunization descriptions and data received.
- Screening information, including screening type (e.g., well visit, vision, hearing, dental).

The MCS is available as a PDF file which can be printed, and a CloneCD, which can be uploaded into the provider's electronic medical record.

AmeriHealth Caritas

Member Clinical Summary

Date of Report: 05/10/2015

Member Information

Name : [redacted]
Address1 : [redacted]
Address2 :
City/St/Zip : [redacted]
Phone : [redacted]
Gender : [redacted]
DOB : [redacted]
Member ID : [redacted]

PCP Information

Provider Name : STELLA VICTORIA G.
Address1 : 145 N 6TH ST 2ND FL
Address2 :
City/St/Zip : Reading, PA 19601-3096
Phone : 610-378-2440

Medications (within past 06 months)

Fill Date	Name & Strength	Days Supply	Prescriber Name	Pharmacy Name
5/6/2015	ACETAMINOPHEN-COD #3 TABLET	10	Sandhya Prasad	RITE AID PHARMACY 01581
5/6/2015	PAIN RELIEVER 500 MG CAPLET	30	Sandhya Prasad	THE COMMUNITY PHARMACY
4/20/2015	VITAMIN B-6 50 MG TABLET	20	Dawn M Liberto	PENN PHARMACY
4/20/2015	PROMETHAZINE 12.5 MG TABLET	7	Dawn M Liberto	PENN PHARMACY
3/7/2015	BETAMETHASONE DP AUG 0.05% CRM	30	Kristi L Hackman	RITE AID PHARMACY 01581

Chronic Conditions

There are no data records available for this section

Gaps in Care

Condition	Service	Status	Last Service	Next Service	Rule
Preventive Health Screens	Adults Access to Care	Due soon	06/19/2014	06/19/2015	At least once per year
Critical Quality Incentive	Cervical Cancer Screen	Up-to-date	03/05/2014	03/05/2017	Once every 3 to 5 years test dependent

ER Visits (within past 06 months)

Date	Facility	Reason
03/07/2015	READING HOSPITAL	OTHER PSORIASIS AND SIMILAR DISORDERS - Emergency department visit for the evaluation and management of a patient which requires these three key components: an

Inpatient Admissions (within past 06 months)

From Date	To Date	Facility	Reason

There are no data records available for this section

Office Visits (within past 06 months)

Date	Provider Name	Speciality	Reason

There are no data records available for this section

Imaging

Date	Facility	Reason
9/2/2014	CURTIN WILLIAM M.	76819 -Fetal biophysical profile; without non-stress testing
6/23/2014	TESTA CHRISTOPHER J.	7681626-Ultrasound pregnant uterus real time with image documentation follow-up eg re-evaluation of fetal size by measuring
6/23/2014	ST JOSEPH MEDICAL CENTER	76816TC-Ultrasound pregnant uterus real time with image documentation follow-up eg re-evaluation of fetal size by measuring

Exhibit 9.1.6-A: Member Clinical Summary Overview

Member care plan

Through the Provider Web Portal, the PCP can also access the member's care plan. The care plan contains goals, interventions and responsible parties based on the member's prioritization.

Care gap alerts

Additionally, providers entering a member ID number into the Provider Web Portal will receive an alert if that member has care gaps. Care gaps are clinically recommended services based on evidence-based clinical practice guidelines for which there is no claim evidence that the member received the service. We evaluate claim data at least monthly for all members. Care gap algorithms exist for a full range of preventive services and chronic disease states.

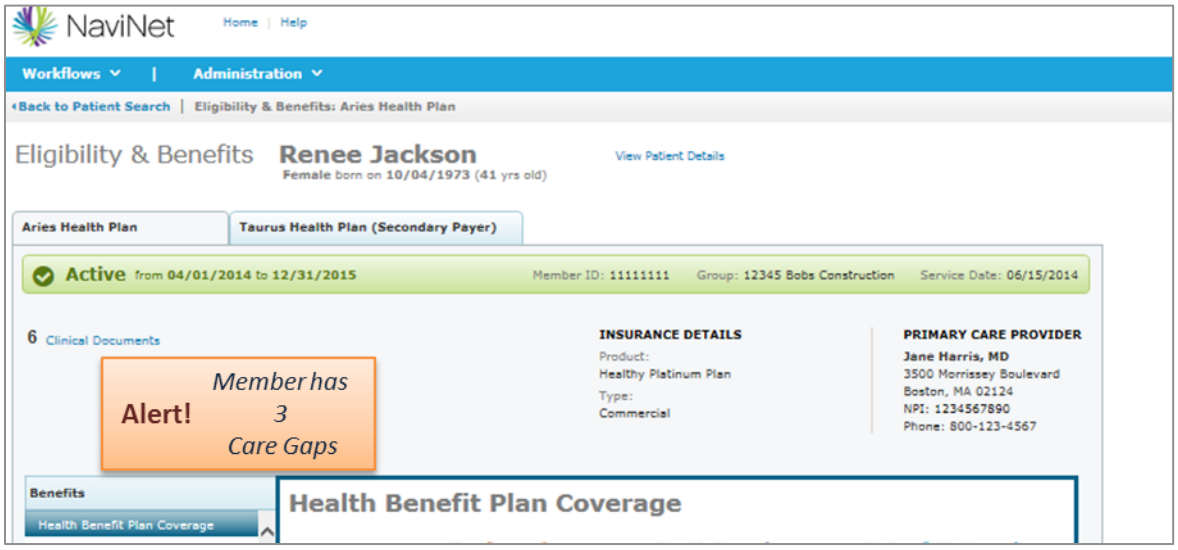

Exhibit 9.1.6-B: Care Gap Alerts Display on the Provider Web Portal

8. Describe how cultural considerations of the member would be accounted for in the care planning process and how the process will be conducted in plain language and accessible to members with disabilities or limited English proficiency.

Cultural consideration

AmeriHealth Caritas Iowa fully recognizes the importance of addressing the needs of members in a culturally competent and linguistically appropriate manner from a philosophy of promoting health equity. This is an integral part of our overarching strategy to deliver person-centered care and reduce health disparities. Accordingly, AmeriHealth Caritas Iowa agrees to continue our successful and consistent practice of ensuring that services are provided to all members in a manner that values, affirms and respects their worth and protects and preserves their dignity.

AmeriHealth Caritas Iowa promotes diversity and inclusion in our efforts to help the underserved and chronically ill stay well and build healthy communities. Among our eight defined organizational values are advocacy, dignity and diversity — elements that are critical in culturally competent care.

Through our comprehensive assessment we collect information on cultural and religious preferences related to healthcare. We identify the member's preferred language by leveraging bilingual staff and interpreters (live and telephonic), though ensuring that the care plan process is conducted in a language that the member is comfortable with. We also tailor our printed materials in different languages and can use a telecommunications device for the deaf (TTD)/teletypewriter (TTY) or an in-person visit with a sign-language interpreter for the hearing impaired.

Finally, we assess for cultural considerations and use a cultural guide to help us understand the differences within cultures. Annually, care managers receive refresher training on healthcare preferences associated with different subpopulations.

All AmeriHealth Caritas Iowa associates are trained upon hire and annually thereafter in Culturally and Linguistically Appropriate Services (CLAS) standards and health equity. This helps engrain our philosophy throughout the organization so that all associates are empowered to help members receive equal access to care. We also provide this training to our physician and dental communities. Recently, the Medicaid medical director for the State of Louisiana requested our CLAS training materials to share with her staff.

Use of plain language

Where ever possible, our care managers use non-clinical terms when discussing health issues and developing care plans with the members. We understand the relationship between low health literacy, poor health outcomes and the associated impact on healthcare costs. Members with low health literacy — those who cannot read, understand or act on health information and instructions — face multiple health risks. Confusion about or lack of healthcare information may result in poor control of chronic illnesses, more hospitalizations and longer lengths of stay, and improperly taken medications.

All of our written materials adhere to literacy and plain language guidelines. We follow a documented process to produce all communication materials in accordance with cultural competency and literacy requirements. Materials are available in alternative formats to members with specialized needs. Strategies that help us accomplish this include:

- Using simple vocabulary to convey information and minimizing the use of medical jargon.
- Using language that is at or below a sixth-grade reading level.
- Choosing appropriate design formats that maximize white space and include easy-to-read fonts and layouts.
- Translating materials into Spanish, Vietnamese and other alternate languages.
- Making materials available in alternate formats (e.g., large print, Braille, compact disc, audiotape).
- Testing our materials with member focus groups.
- Using diverse graphics on materials to engage members.

AmeriHealth Caritas Iowa's member materials are developed by associates who undergo annual training in cultural competency and are instructed in health literacy and reading-level requirements. Our writers use a toolkit adopted from the work of the Partnership for Clear Health Communication at the National Patient Safety Foundation to ensure that our communications to members are easy to understand and culturally competent.

Members with disabilities

For members who are unable to communicate their needs through spoken words, we use a variety of techniques to ensure their inclusion in the care planning process. Care managers can use chalkboards or picture/word boards to understand member preferences and goals for non-verbal members. For members

who are hearing impaired, sign-language interpreters or TTD/TTY systems can be used to conduct the conversation.

Members with limited English proficiency

For members who are not proficient in English, interpreters or bilingual care management staff are used to conduct care planning conversations. For in-person conversations, the interpreter will be brought to the meeting, when possible. For language needs that are not common in the population, AmeriHealth Caritas Iowa will employ the services of Language Services Associates to provide real-time language interpretation. Language Services Associates is able to provide interpretation services in over 200 languages.

In addition, AmeriHealth Caritas Iowa will translate written materials into needed languages. Many materials are already available in Spanish. We contract with a translation service capable of translating materials into over 100 languages.

AmeriHealth Caritas Iowa maintains a current demographic and cultural profile of our members. We use this profile to plan services accordingly. AmeriHealth Caritas Iowa will continually monitor the special needs of our members by reviewing monthly demographic reports that include racial, ethnic and preferred language information.

We monitor the language line to identify emerging trends. Through our annual Language Access Services survey, we survey a sampling of members, providers and internal associates to gain feedback on the provision of our language services.

In 2014, we provided interpreter services for over 58,000 member interactions. The top 10 languages requested appear below and provide insight into the depth of services we can offer:

- Spanish.
- Arabic.
- Mandarin.
- Haitian Creole.
- Gujarati.
- Vietnamese.
- Korean.
- Russian.
- Portuguese.
- Cantonese.

For additional information regarding these Member Services, please see our response in Section 8.2.

Success story: Meeting a member's language needs

Our care manager reached out on behalf of Mariam, a member of our affiliate plan in Louisiana, who was pregnant. The only contact number available belonged to Mariam's husband. After the care manager attempted several times to contact the member's husband without success, he called back when he was with Mariam. The care manager got permission from Mariam to speak with her husband about her care. The care manager learned that Mariam speaks only Urdu, but her husband speaks English.

The husband related that he was having trouble getting Mariam's progesterone prescription refilled. The care manager related that prior authorization may be needed from Mariam's doctor. The care manager called PerformRx℠, our prescription benefits manager, and after confirming that prior authorization was needed, reached out and left a message with Mariam's doctor.

The care manager then followed up with Mariam's husband to let him know the status. He informed the care manager that Mariam was seeing a different doctor as a result of a complication with her pregnancy. He provided the name of the new doctor. The care manager indicated that she would call the doctor,

inform him of the need for prior authorization of the prescription and get back in touch with Mariam's husband.

During this conversation, Mariam's husband expressed his concerns about interpreting for his wife. The care manager reassured him that she would use the services of an interpreter. Satisfied that Mariam would be able to communicate her needs to the care manager through this means; her husband gave the care manager Mariam's personal cell phone number.

The care manager called the doctor's office to provide prior authorization instructions and followed up once more with Mariam's husband. She let him know that he could call the doctor's office for further instructions or reach out again to the care manager with any problems. He expressed his gratitude for all of the assistance in getting the medication refilled.

Utilizing the Urdu language line, the care manager then reached out to Mariam directly to engage her in her care and learn of any other needs she had. Mariam agreed to have educational materials mailed to her In Urdu. The case manager reached out to the plan's CLAS coordinator to request translation of materials into Urdu for Mariam. The team arranged for the translation into Urdu for the Welcome Packet, as well as educational materials targeted to Mariam's needs, including "Fetal Kick Count" and "Understanding Pre-term Labor." These were then mailed to Mariam.

The care manager reached out to Mariam again after she delivered her baby. Mariam confirmed that she had received the translated materials and offered her thanks.

9. Describe how the proposed care plan process will include a system to monitor whether the member is receiving the recommended care

In addition to developing a sound person-centered care plan, AmeriHealth Caritas has a process in place to monitor whether the member is receiving the recommended care. Within our care plan, we place reminder follow-ups to review activities and interventions the member or the care manager is providing to the member.

- Our population health management system, Jiva, has the ability to set follow up dates to review the care plan outcomes with the member. For members receiving in-home services, we will review satisfaction with services and timely delivery of services.
- We mine our member data to generate care gaps for services recommended based on age, gender and condition for which there is no evidence of completion. These gaps are disseminated through our alert system (populating the member service, care management and Provider Web Portal systems). This triggers outreach, including automated calls and text messages, and is also detailed on provider reports to enable PCP and Health Homes practices to best manage their populations.
- With our PBM services, we monitor prescription refill timeliness for key medications and trigger outreach when the refill is not obtained within seven days of being due
- For members receiving in-home LTSS, we plan to contract with providers who utilize electronic visit verification systems. Per AmeriHealth Caritas standards, visit completion data will be reviewed weekly by the AmeriHealth Caritas Iowa care management team.

9.1.7 Tracking and reporting

1. Describe how you propose to track and report on care coordination programs and share care coordination information with the member, authorized representative and treatment providers.

Tracking and reporting is an important step in care coordination in order to help achieve the best outcomes for members. AmeriHealth Caritas Iowa has the ability to track the results of the initial health risk screening, comprehensive health risk assessment, the care plan, member outcomes and has the ability to share care coordination information with the member, their authorized representatives and all relevant treatment providers.

Program-level data

AmeriHealth Caritas Iowa tracks, evaluates and reports several data elements at the program level:

- Participation rates are tracked by calculating the number of members enrolled in a program segment divided by those who were identified for the program.
- Members with an active care plan are assigned an acuity level based on the level of contact and services needed to support the member's plan of care.
- HEDIS outcomes are used to monitor clinical guideline adherence and health outcomes.
- EPSDT participation.
- Cost and utilization reports.
- Member and provider satisfaction with program services.

PCPs receive additional program-level outcome data specific to their assigned members through panel-level outcome reports. These reports show outcomes for key program metrics, such as preventive care and diabetes management, and comparative rates for a peer group of physicians. Similar reports are also produced for cardiologists and obstetricians.

Annually, AmeriHealth Caritas Iowa will perform a comprehensive evaluation of its care coordination programs to identify successful strategies and areas where opportunities exist for improvement. This information is used to guide and inform program changes in the subsequent year.

Highlights of the program-level evaluation are shared with AmeriHealth Caritas Iowa members, representatives and providers through a Report to the Community.

Member-level care coordination

Information related to care coordination plans and activity for individual members is shared through several mechanisms, including our secure Web portals, care management team meetings, and, upon request, mailed paper documents.

Member access

Members and caregivers/representatives authorized by the member can access clinical information on the Member Clinical Summary (MCS) (described in Section 9.1.6.7, above) and the member's care plan. The MCS contains information on identified conditions, missing or overdue services (care gaps), recent inpatient admissions and emergency room visits, medications received from the pharmacy, specialty type and visit dates for providers involved in the member's care, radiology procedures, and key laboratory

results. For pediatric members, the MCS also contains a list of all immunizations and EPSDT screenings in the claim history.

The care plan contains the goals identified by the member and the agreed upon steps to meeting those goals, along with start and target end dates. The care plan also lists members of the care team, emergency contacts and information on community service organizations supporting the plan. Members and their representatives can also submit notes related to the care plan for the care manager to review. Both documents are formatted for printing.

For members who do not have access to the Member Portal, or who request to have hard copies of the documents, the care manager will arrange to mail or deliver copies.

PCP and specialist access

PCPs and specialists involved in the member's care can access the same set of documents (Member Clinical Summary and care plan) through the secure Provider Web Portal. All participating providers have access to the MCS from the member's eligibility screen. This access allows providers who are seeing a member for the first time or treating a member in the emergency room to have information on the member's medical history and medications at their fingertips. The medication refill dates on the MCS is also valuable to physicians (PCPs and specialists) who are trying to understand if the reason a medication is not having the desired effect is that the patient requires a higher dose or the patient is not filling the prescription.

Access to the member's care plan is granted based on a link to the provider in the member's plan of care. PCPs are automatically linked to the care plan. Specialists are added as care team members by the care manager during the care plan development process with the member. Once added as a care team member, the specialist can access the member's plan of care through the secure Provider Web Portal and submit notes related to the care plan for the care manager to review.

Behavioral health provider access

Behavioral Health providers have the same access to the MCS and the care plan as other specialists. They are able to access the MCS from the member's eligibility screen. Once added, with the member's consent, as a care team member, the behavioral health provider can access the member's plan of care and submit notes related to the care plan for the care manager to review.

Other providers and community organizations

The AmeriHealth Caritas Iowa Member Portal also provides access to the member's care plan for other providers and community organizations that are identified as part of the member's care team. With agreement from the member, the care manager will add the provider/community organization representative to the care team record in Jiva. Once added, the representative can access the member's plan of care through our secure portal and submit notes related to the care plan for the care manager to review.

2. Describe the system that you will use to integrate and share information about members in order to facilitate effective care coordination

Our care management information system, Jiva, is used to integrate and share information about the member to facilitate care coordination. Jiva integrates care management, utilization records and clinical data. The system contains claim history, assessment responses, care plan goals, interventions, barriers and problems, authorization history, blood test results, medication history, care gaps and call records.

The Jiva application is a collaborative healthcare management platform for case and disease management, preventive health (EPSDT) and utilization management. Jiva serves as the core system of our Integrated Care Management program. Jiva's extensive capabilities, coupled with our robust analytic and data mining capabilities, form a comprehensive care management information system. Highlights of our system capabilities include:

- Defined business rules that automatically evaluate care requests to determine whether the request should be approved or pended for further review.
- Clinical rules for clinical consistency in care management processes, based on evidence-based medicine, reference materials, industry-standard best practices and physician expertise.
- Identification and stratification of target patients and populations to set appropriate levels of intervention and improvements for a member's care.
- Integrated access to medical, pharmacy, lab and behavioral health data to provide a 360-degree view of the member.
- A series of care management clinical pathways that enable the efficient implementation of our holistic approach to the management of chronic conditions, pregnancy, pediatric preventive care and quality management initiatives that reduce costs and improve the health outcomes.
- Comprehensive outreach pathways that incorporate current member needs, health reminders and missed service strategies.
- Integrated correspondence that allows automatic generation of customized faxes, letters and email based on approved letter templates.
- Robust reporting templates and the ability to create ad hoc reports for care management data.
- Provider Web Portal interface allowing providers to create, update and view information on medical necessity authorizations and determinations.
- Clinically validated care gaps and electronic health records derived from claims and care management data.
- Through Jiva's workflow capabilities, care managers can set reminder activities to ensure care plan follow-up and add activities to the member's plan of care to prompt other members of the care team to complete work, such as schedule transportation or call with an appointment reminder. The system's 360-degree view of the member puts all available data at the fingertips of care team members.
- Sensitive messaging functionality allows care team members to place an alert on the member's record to notify anyone reviewing the record of key information, including changes in guardianship and information sharing restrictions. Screen displays visually alert care team members to changes in the member's status, such as admission to the hospital.
- Access to Jiva is integrated in our secure Provider Web Portal, providing seamless entry for users without the need to re-enter user ID and password information. Through Provider Web Portal, providers can access key member information including the member's care plan and submit notes related to the care plan for the care manager to review.

9.1.8 Monitoring

1. Describe your care coordination monitoring strategies.

AmeriHealth Caritas Iowa performs ongoing monitoring of the care coordination program at the program level, member level and care team level. Results from monitoring activities are used to drive improvement activities.

- **Care management caseloads** — The number of cases and case-load acuity weight is reviewed weekly for each care manager. This activity allows the care management supervisors to direct referrals and make assignment adjustments to ensure that a care manager has the capacity to meet the care management needs of the assigned members.
- **Care management audits** — On a quarterly basis, a sample of care management case documentation, including assessment timeliness, care plan content and currency, and outreach frequency, are audited for each care manager. Results are used to provide individual coaching and education for care managers, as well as to identify education opportunities for the whole team.
- **Motivational interview coaching** — On a quarterly basis, a motivational interview coach listens to interactions between the care manager and the member. Feedback on the use of motivational interviewing techniques is provided to the individual care manager to strengthen the care manager's skill set.
- **Health outcomes** — Monthly and annual health outcome data is collected and reviewed to monitor the impact of care coordination interventions. Where possible, industry-accepted metrics are utilized, including HEDIS, CHIPRA and PPEs.
- **Process monitoring** — Weekly reports are used to monitor key process steps, including new member assessment completion, overdue care plan activities and LTSS member contacts.

Annually, a comprehensive evaluation of the Integrated Healthcare Management program is conducted for each segment of the program, including pediatric preventive health (EPSDT), Bright Start, complex care management, women's health and LTSS. Outcomes and recommendations are reported to the Quality of Clinical Care Committee and the Quality Assessment Performance Improvement Committee.

2. Describe how case specific findings will be remediated.

During our monthly departmental review, we look and set timelines for areas of improvement. The monthly review includes case audit results, program challenges and plans to improve operations. For example, during a recent review, an affiliate Pennsylvania health plan identified that the existing staff structure and caseloads were not providing enough time to conduct needed new assessments. In response, they were restructuring their care management positions to dedicate one care manager to just handle new assessments.

In addition, each year after the program's annual review, at least two opportunities for improvement are identified, and interventions are put in place to address those areas. During the last year, these efforts have resulted in the expansion of care management into the community through placement of additional embedded care managers and the launch of four Community Care Management teams. In addition, a motivational interviewing coach position was created and hired to strengthen staff skills for this important technique.

9.1.9 Reassessment

1. Describe in detail your process for reviewing and updating care plans.

Care plans are reviewed and updated on an as needed basis, at a minimum each time a member is contacted. Care plans are updated no less than annually. Members or providers can also request reassessment. Additionally, outside of normal contact, there are several triggers that immediately move a member to a more assertive level of care, including a new diagnosis, an inpatient admission or an emergency room contact.

Jiva includes a system to set timeframes for the next contact with the member. The system automatically places those activities on a calendar on the care manager's work screen. The care manager can block days on the calendar when he/she is not available, so that activities are not scheduled during those times. Supervisors can also access the calendar for care managers on their team. This allows the supervisor to reassign planned contacts for care plan reevaluation when the care manager is unexpectedly not available.

Members who experience an event, such as an inpatient admission or an ER visit are flagged in the system with the addition of a visual "widget" to the member screen. In addition, the system automatically creates a care management activity that is placed on the care manager's work list with an urgent priority level. This alerts the care manager that the member needs to be contacted for reassessment and adjustments to the plan of care.

Gerri is a one-year-old with Stickler syndrome (congenital face and eye abnormalities, joint pain and hearing loss) and gastric reflux. Her care manager connected Gerri's mother to WIC and food stamp programs to bring additional nutrition in the home, and Healthy Families and First Steps programs for additional support and monitoring. She continued contact with Gerri's mother to follow up on Gerri's attendance at well child appointments.

During a recent routine call, Gerri's mother was crying on the phone. She told the care manager that the family's home burned down the night before. Three of their dogs died in the fire. Fortunately, the mother, her boyfriend and Gerri's maternal grandmother escaped without harm. The family was staying next door with a relative.

The care manager contacted the local county Salvation Army, local Red Cross Chapter, local churches and other community organizations. Since Gerri's mother was so upset, the care manager, with the mother's consent, made the calls on behalf of the family.

A few days later, in a follow-up call, Gerri's mother related that she had received positive responses from many of the connections, and had already received assistance from the Red Cross, Salvation Army and a local church. She was also contacting WIC to replace the vouchers lost in the fire. She was making arrangements to move into a trailer and planned to use some of the money from the Red Cross for furniture. The care manager increased the follow-up schedule for Gerri and her mother to ensure that Gerri's appointments were kept and needs were met as Gerri's family continued to adjust to their new circumstances.

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2. Describe the protocol that you will use for re-evaluating members to determine if their present care levels are adequate.

AmeriHealth Caritas Iowa uses a series of assessment tools to re-evaluate members' care levels. At each contact with a member of the Care Management staff, an urgent needs screen is conducted to identify changes in the member's condition and barriers to obtaining services and medications. Positive answers to this short set of questions triggers more in-depth analysis by the care connector or care manager.

In addition, the Care Management team conducts routine re-evaluations using condition-specific monitoring tools, such as the Asthma Control Test. Available for all of the targeted chronic conditions, these tools address important aspects of the evidence-based condition management protocols. Members whose response indicates a change in condition or a gap in services undergo a re-evaluation to identify appropriate care levels.

Care levels are also re-evaluated as members demonstrate improved self-management skills. The care manager will monitor actions the Member is able to complete with lower levels of support. For example, a member who needs to make ongoing appointments with a cardiologist may initially need the care manager to prompt the member and schedule the appointment using a three-way call between the member, care manager and provider office. As the member becomes more confident in his/her ability to take action in support of the care plan, the care manager may just need to remind the member to schedule the appointment. As the member's self-management skills continue to strengthen, the care manager may just need to follow-up to confirm with the member that the appointment was made.

Trigger events also lead to a re-evaluation of care levels. High-risk and LTSS members who are admitted to the hospital are automatically re-evaluated to identify opportunities to augment existing services. For Members eligible for or actively receiving LTSS, AmeriHealth Caritas Iowa's care manager will conduct level of care reassessments in-person, using DHS designated tools, to determine an enrollee's continued functional eligibility for LTSS (HCBS and nursing facility [NF]). These reassessments will occur when the plan becomes aware that the member's functional or medical status has changed in a way that may affect level of care eligibility. Examples of triggers that would indicate an earlier reassessment include:

- A transition in care or setting (e.g., hospital to home; hospital to skilled nursing facility [SNF], rehabilitation facility or ICF/ID; SNF, rehabilitation facility or ICF/ID to home).
- Significant change in health or psychosocial status, including change in caregiver status.
- Request for service, when member or his or her designated representative believes that the individual needs to initiate, eliminate, or continue a particular service.

3. Indicate the triggers which would immediately move the member to a more assistive level of service.

There are several triggers that immediate move a member to a more assistive level of service, including:

- Loss or reduction of caregiver support.
- New diagnosis of a chronic or behavioral health condition.
- Inpatient admission for a chronic or potentially preventable condition.
- Pregnancy.
- Pregnancy complication.
- Entry into foster care or guardianship.
- New diagnosis related to EPSDT screening or developmental milestones.

- Catastrophic event, such as a motor vehicle accident or burn.
- Change in functional status, such as a fall or loss of motor function (including mobility and speech).
- Change in ability to manage activities of daily living.
- Change in cognitive status.

As stated earlier, AmeriHealth Caritas' IHM program is a holistic solution that is in-place to provide comprehensive care coordination services. Using our tools and leveraging our expertise, AmeriHealth Caritas Iowa will be able to provide the care coordination services needed to ensure improved outcomes at greater efficiency for DHS and Iowa members.

Attachment 9.1.1-A: Wellsource HRA (example/subset)

HRA 205 Question Set

April 6, 2015

First name

- [Input Box]

Last name

- [Input Box]

When were you born?

- [Input Box]

Are you male or female?

- Male
- Female

What is your race?

American Indian or Alaskan Native

You can be more than one race group. Say "yes" if you have origins in any of the original peoples of the Americas (North, Central, and South America). You maintain cultural identification through tribal affiliation or community attachment.

- Yes
- No

Asian

You can be more than one race group. Say "yes" if you have origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent, such as: Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Is

- Yes
- No

Black or African American

You can be more than one race group. Say "yes" if you have origins in any of the black racial groups of Africa.

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- Yes
- No

Native Hawaiian or other Pacific Islander

You can be more than one race group. Say "yes" if you have origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

- Yes
- No

White

You can be more than one race group. Say "yes" if you have origins in any of the original peoples of Europe, the Middle East, or North Africa.

- Yes
- No

Don't know

- Yes
- No

Don't want to say

- Yes
- No

Are you Hispanic, Latino, or of Spanish origin?

You can be any race and also any ethnic origin. Say "yes" if your culture of origin is Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture, regardless of race.

- Yes
- No

Zip code

- [Input Box]

HRA 205 Question Set

April 6, 2015

Country

- [Input Box]

How much school have you finished?

The last grade you finished.

- Grade 1-8
- Grade 9-11
- Grade 12 or High School GED
- Some College
- Bachelor's Degree
- Graduate Degree

Which language do you prefer to speak?

- English
- Español
- 中国
- Tagalog
- Français
- tiếng Việt
- Deutsch
- 한국의
- русский
- العربيـــة

How do you rate your health?

- Great!
- Good
- Fair
- Poor

Compared to one year ago, how do you rate your health?

- Much better
- Some better
- About the same
- Some worse
- Much worse

HRA 205 Question Set

April 6, 2015

What is your outlook on your future?

- Don't look forward to the future
- Not sure what the future holds
- Hopeful and expect things to work out well

How do you feel about your life?

- Things are very good
- Things are mostly okay
- Things are mostly not okay
- Things are not okay

In the last 4 weeks:

How many days did poor health make you get less done?

Or you did not do as good a job as usual.

- [Input Box]

[CONDITIONAL] How much did your poor health affect you?

Very little: No one noticed a change. Some: You did a worse job, or got less done. A lot: You did at least a third less than normal.

- Very little
- Some
- A lot

How often have you felt stressed?

Stress can make you have tense muscles and headaches, be grumpy, and feel nervous. These can make it hard for you to sleep.

- Never or almost never
- Sometimes
- Often
- All the time

Attachment 9.1.2-A: Comprehensive Assessment — Adult

Initial Assessment — Adults

1. Who is providing responses to assessment questions? Check all that apply.

- ☐ Member
- ☐ Spouse
- ☐ Significant other
- ☐ Parent
- ☐ Guardian
- ☐ Caregiver other than parent or guardian
- ☐ Child of adult member
- ☐ Family member
- ☐ Friend
- ☐ Other

Comments:

2. Is the member willing to participate in the Integrated Care Management (ICM) program? If yes, please read Bill of Rights & Disclosure per LOB policy

- ☐ Yes
- ☐ No

Comments:

Initial Assessment — Adults

3. Which of these condition(s) is/are the member's primary health concern(s)? Document length of time under each condition. Check all that apply.

- ☐ ADHD/ADD
- ☐ ALS
- ☐ Alzheimer
- ☐ Anxiety
- ☐ Asthma
- ☐ Autism
- ☐ Behavioral/Mental Disability
- ☐ Bipolar
- ☐ Bronchiolitis
- ☐ CAD
- ☐ Cancer
- ☐ Cellulitis
- ☐ Cerebral Palsy
- ☐ Chest Pain
- ☐ Chronic Pain
- ☐ Cirrhosis
- ☐ Congenital Anomalies
- ☐ COPD/Emphysema
- ☐ Crohn's Disease
- ☐ CVA/Stroke
- ☐ Cystic Fibrosis
- ☐ Depression
- ☐ Developmental Delay/
- ☐ Diabetes
- ☐ Drug Overdose
- ☐ End Stage Liver disease
- ☐ ESRD/CRF
- ☐ Failure to Thrive
- ☐ GERD
- ☐ Hearing Impaired
- ☐ Heart Failure
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ HIV/AIDS (self disclosed)
- ☐ HTN
- ☐ Hyperlipidemia
- ☐ Lymphedema
- ☐ MI
- ☐ MRSA
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Obesity
- ☐ Pancreatitis
- ☐ Panic Disorder
- ☐ Para/Quadriplegia
- ☐ Parkinson's Disease
- ☐ Pneumonia
- ☐ Pregnancy
- ☐ Pre-term labor
- ☐ Psychosocial needs
- ☐ PTSD
- ☐ PVD
- ☐ RAD
- ☐ Respiratory Failure
- ☐ Rheumatoid Arthritis
- ☐ Schizophrenia
- ☐ Seizure Disorder
- ☐ Sickle Cell Disease
- ☐ Spina Bifida
- ☐ Substance Abuse
- ☐ Technology Defect
- ☐ Transplant
- ☐ Traumatic Brain Injury
- ☐ Ventilator Dependent
- ☐ Vision Impaired
- ☐ Other

Comments:

Initial Assessment — Adults

4. What are the member's past health condition(s)? Document length of time next to each condition. Select all that apply. Refer to question #3-same responses.

- ☐ ADHD/ADD ☐
- ☐ ALS ☐
- ☐ Alzheimer ☐
- ☐ Anxiety ☐
- ☐ Asthma ☐
- ☐ Autism ☐
- ☐ Behavioral/Mental ☐
- ☐ Bipolar ☐
- ☐ Bronchiolitis ☐
- ☐ CAD ☐
- ☐ Cancer ☐
- ☐ Cellulitis ☐
- ☐ Cerebral Palsy ☐
- ☐ Chest Pain ☐
- ☐ Chronic Pain ☐
- ☐ Cirrhosis ☐
- ☐ Congenital Anomalies ☐
- ☐ COPD/Emphysema ☐
- ☐ Crohn's Disease ☐
- ☐ CVA/Stroke ☐
- ☐ Cystic Fibrosis ☐
- ☐ Depression ☐
- ☐ Developmental Delay/Disability ☐
- ☐ Diabetes ☐
- ☐ Drug Overdose ☐
- ☐ End Stage Liver disease ☐
- ☐ ESRD/CRF ☐
- ☐ Failure to Thrive ☐
- ☐ GERD ☐
- ☐ Hearing Impaired ☐
- ☐ Heart Failure ☐
- ☐ Hemophilia ☐
- ☐ Hepatitis ☐
- ☐ HIV/AIDS (self disclosed) ☐
- ☐ HTN ☐
- ☐ Hyperlipidemia ☐
- ☐ Lymphedema ☐
- ☐ MI ☐
- ☐ MRSA ☐
- ☐ Multiple Sclerosis ☐
- ☐ Muscular Dystrophy ☐
- ☐ Obesity ☐
- ☐ Pancreatitis ☐
- ☐ Panic Disorder ☐
- ☐ Para/Quadriplegia ☐
- ☐ Parkinson's Disease ☐
- ☐ Pneumonia ☐
- ☐ Pregnancy ☐
- ☐ Pre-term labor ☐
- ☐ Psychosocial needs ☐
- ☐ PTSD ☐
- ☐ PVD ☐
- ☐ RAD ☐
- ☐ Respiratory Failure ☐
- ☐ Rheumatoid Arthritis ☐
- ☐ Schizophrenia ☐
- ☐ Seizure Disorder ☐
- ☐ Sickle Cell Disease ☐
- ☐ Spina Bifida ☐
- ☐ Substance Abuse ☐
- ☐ Technology Defect ☐
- ☐ Transplant ☐
- ☐ Traumatic Brain Injury ☐
- ☐ Ventilator Dependent ☐
- ☐ Vision Impaired ☐
- ☐ Other ☐

Comments:

Initial Assessment — Adults

5. What current treatments does the member receive?
Document when treatment began and expected length of time under each selected item. Select all that apply.

- ☐ None
- ☐ Behavioral Health Therapy
- ☐ Substance Abuse Treatment
- ☐ Cardiac Rehab
- ☐ Dietary Restrictions
- ☐ DME
- ☐ Home Health Care
- ☐ Medication Management
- ☐ Occupational Therapy
- ☐ Oxygen
- ☐ Physical Therapy
- ☐ Skilled Nursing
- ☐ Speech Therapy
- ☐ Wound Care
- ☐ Other

Comments:

6. What past treatments has the member received?
Document when treatment was received under each selected item. Select all that apply.

- ☐ None
- ☐ Behavioral Health Therapy
- ☐ Substance Abuse Treatment
- ☐ Cardiac Rehab
- ☐ Dietary Restrictions
- ☐ DME
- ☐ Home Health Care
- ☐ Medication Management
- ☐ Occupational Therapy
- ☐ Oxygen
- ☐ Physical Therapy
- ☐ Skilled Nursing
- ☐ Speech Therapy
- ☐ Wound Care
- ☐ Other

Comments:

Initial Assessment — Adults

7. How often does the member see their primary medical provider?

- ☐ Weekly
- ☐ Twice a month
- ☐ Monthly
- ☐ Every two months
- ☐ Every three months
- ☐ Every six months
- ☐ Yearly
- ☐ As needed
- ☐ Other

Comments:

8. Does the member receive care from a specialist(s)? Select all that apply.

- ☐ Yes
- ☐ Adolescent Medicine
- ☐ Cardiologist
- ☐ Dentist/Oral Surgeon
- ☐ Dermatologist
- ☐ Developmental Pediatrician
- ☐ Endocrinologist
- ☐ ENT
- ☐ Gastroenterologist
- ☐ OB/GYN
- ☐ Hematologist/Oncologist
- ☐ Infectious Disease
- ☐ Neonatologist
- ☐ Nephrologists
- ☐ Neurologist
- ☐ Nutrition/Wt Management
- ☐ Oncologist
- ☐ Ophthalmologist
- ☐ Orthopedic
- ☐ Pain Management
- ☐ Perinatologist
- ☐ Psychiatrist/Therapist
- ☐ Podiatrist
- ☐ Pulmonologist
- ☐ Rheumatologist
- ☐ Surgeon
- ☐ Wound Care
- ☐ Other
- ☐ No

Comments:

Initial Assessment — Adults

9. What surgeries has the member had?
Document when surgery was performed under each selected item. Select all that apply.

- ☐ None
- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Bariatric Surgery
- ☐ Bone Marrow Transplant
- ☐ Breast Biopsy
- ☐ Carotid Endarterectomy
- ☐ Cataract Surgery
- ☐ Cesarean Section
- ☐ Cholecystectomy
- ☐ Colectomy
- ☐ Coronary Artery Bypass Surgery
- ☐ Debridement of wound, burn or infection
- ☐ Dilation and Curettage (D&C)
- ☐ Excision of Malignancy
- ☐ Hemorrhoidectomy
- ☐ Hysterectomy
- ☐ Limb Amputation
- ☐ Mastectomy
- ☐ Organ Transplant
- ☐ Prostatectomy
- ☐ Skin Graft
- ☐ Tonsillectomy
- ☐ Total Hip Replacement
- ☐ Total Knee Replacement
- ☐ Tracheostomy
- ☐ Other

Comments:

10. What is the member's most recent height and weight, calculate BMI and select BMI range.

- ☐ Height
- ☐ Weight

Underweight: BMI = < 18.5
Normal Weight: BMI = 18.5 - 24.9
Overweight: BMI = 25-29.9
Obese: BMI = or greater than 30

- ☐ N/A

Comments:

Initial Assessment — Adults

11. I would like to review the member's medications, including over the counter meds and samples. I want to make sure they match our records.

List medications, when started, strength, frequency, route/technique used, any problems with taking the medications. If member is unable to provide information, document why.

Comments:

12. Does the member have any environmental allergies or medication allergies? If yes, please list allergies, type of reaction and date.

- ☐ Yes
- ☐ Breathing difficulties
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Tongue swells
- ☐ Other (explain)
- ☐ No
- ☐ Unknown

Comments:

Initial Assessment — Adults

13. Does the member use or have used any of the following? If yes, how much and when (date). Select all that apply. If other, explain.

- ☐ Use Street drugs
- ☐ Methadone
- ☐ Suboxone

Alcohol

- ☐ Rarely
- ☐ More than 5 drinks per day
- ☐
- ☐ 1-2 drinks per day
- ☐ Other (Free Text)
- ☐ 3-4 drinks per day
- ☐ Overuse of prescription drugs

Smoke cigarettes

- ☐ 1 to 10 cigarettes
- ☐ More than 2 packs
- ☐ NA
- ☐ 1 pack
- ☐ Other
- ☐ Other
- ☐ 1 to 2 packs
- ☐ Use of other tobacco products

Comments:

14. Has the member been admitted to the hospital in the past 6 months? If yes, list dates and reasons.

- ☐ Yes
- ☐ No
- ☐ Unknown

Comments:

Initial Assessment — Adults

15. Has the member utilized the emergency department in the past 6 months? If yes, list dates and reasons.

☐ Yes ☐ No ☐ Unknown

Comments:

16. What cultural and/or religious needs, preferences or limitations does the member have that might affect their health care decisions?

☐ None
☐ Blood transfusions/blood products
☐ Dietary practices
☐ Examination by a male/female practitioner
☐ Family traditions
☐ Medications (e.g. pork/beef insulin)
☐ Rx/procedures discouraged/not allowed
☐ Transportation by male/female driver
☐ Other

Comments:

Initial Assessment — Adults

17. Does the member have any language needs, preferences or limitations? Indicate preferred language

☐ Yes ☐ No

Preferred Language-select one

☐ Arabic	☐ Chinese	☐ Somali
☐ Bosnian	☐ English	☐ Spanish
☐ Braille	☐ French	☐ Vietnamese
☐ Burmese	☐ German	☐ Other
☐ Cambodian	☐ Russian	

Comments:

18. Does the member have any problems with vision? If yes, list concerns, date of last vision exam and corrective devices.

☐ Yes ☐ No

Comments:

19. Does the member have any problems with hearing? If yes, list concerns, date of last hearing test and corrective devices.

☐ Yes ☐ No

Comments:

Initial Assessment — Adults

20. Has the member been seen by a dental provider in the last six months? If other, explain.

- ☐ Yes
- ☐ No
- ☐ Unknown

Comments:

21. When the member is given things to read about their health, do they have any problems reading them? Select all that apply.

- ☐ No problem
- ☐ Can't read at all
- ☐ Unable to read some of the words
- ☐ Can't see well enough to read
- ☐ Not in main/preferred language
- ☐ Difficulty understanding materials
- ☐ Don't like to read
- ☐ Other

Comments:

Initial Assessment — Adults

22. Does the member have any self care deficits related to any of the following? Select all that apply.

- ☐ Ambulate Independently
- ☐ Bathe
- ☐ Dress yourself
- ☐ Exercise at least 20 minutes at a time(Free Text Box)
- ☐ Feed yourself
- ☐ Groom yourself
- ☐ Laundry
- ☐ Light housekeeping
- ☐ Looking up phone numbers
- ☐ Managing money
- ☐ Prepare meals
- ☐ Read in your preferred language
- ☐ Shopping
- ☐ Toileting
- ☐ Using the telephone
- ☐ Other

Comments:

23. Has the member missed work, school or had to limit daily activities because of their condition(s)?

- ☐ Yes
- ☐ No

Comments:

Initial Assessment — Adults

24. What is the member's living arrangement? If other, please list.

- ☐ Alone
- ☐ With a spouse/partner only
- ☐ With spouse/partner and others
- ☐ With child only
- ☐ With parent(s) or guardian (s)
- ☐ Sibling(s)
- ☐ With other relative(s)
- ☐ With non-relative(s)
- ☐ Homeless
- ☐ Shelter
- ☐ Group home
- ☐ Residential Treatment
- ☐ Facility
- ☐ Other

Comments:

25. Does the member have problems accessing the home? Select all that apply.

- ☐ Yes
- ☐ No difficulty

Comments:

26. If the member has problems accessing the home, please select all that apply.

- ☐ Difficulty with entering or leaving the house
- ☐ Difficulty with navigating in the house
- ☐ Stairs make it difficult or impossible to leave the house
- ☐ In wheelchair with no ramp or elevator
- ☐ Difficulty with transfer
- ☐ Too Weak to leave the house
- ☐ Other

Comments:

Initial Assessment — Adults

27. Do you feel safe in your current environment?

☐ Yes ☐ No difficulty

Comments:

28. Was there a time in your past you did not feel safe in your environment?

☐ Yes ☐ No difficulty

Comments:

29. How does the member get from room-to-room in the home? Select all that apply.

☐ Ambulatory-no difficulty ☐ Use of walker ☐ Bedridden

☐ Use of cane ☐ Use of wheelchair ☐ Other

Comments:

30. Does the member have or need assistance with caregiving?

☐ Yes ☐ No difficulty

Comments:

Initial Assessment — Adults

31. Yes, indicate level of involvement.

- ☐ Caregiver currently provides assistance
- ☐ Caregiver is not likely to provide assistance
- ☐ Assistance needed but no caregiver available
- ☐ Caregiver needs training, supportive service
- ☐ Unclear if caregiver will provide assistance

Comments:

32. Does the member give the CM permission to speak to caregiver? Please indicate name and contact information for caregiver if provided.

- ☐ Yes
- ☐ No
- ☐ n/a

Comments:

33. Is the member/caregiver aware of member's health care benefits and any service limits such as pharmacy, home care, DME, etc.?

- ☐ Yes
- ☐ No, explain to the member the benefits that are available

Comments:

Initial Assessment — Adults

34. If member/caregiver is not aware of health care benefits and any service limitations, please select all topics on which member needs to be educated

- ☐ 24 hour Nurse Line
- ☐ Language Line
- ☐ Medicaid Transportation
- ☐ Member Services
- ☐ Mental Health Services
- ☐ Primary Medical Provider
- ☐ Rapid Response Outreach Team
- ☐ Other

Comments:

35. Does the member have health care needs that are not covered benefits? Please list needs and referrals, if indicated.

Comments:

36. What type of transportation does the member use for medical appointment/services? Select all that apply.

- ☐ Ambulance
- ☐ Cab
- ☐ Public transportation
- ☐ Medical Assistance
- ☐ Medicaid Transportation
- ☐ Caregiver
- ☐ Family/Friends
- ☐ Self
- ☐ Walking
- ☐ No reliable means
- ☐ Other

Comments:

Initial Assessment — Adults

37. Is the member/caregiver aware of where to go for services within the community, such as, urgent care services, stop smoking classes, diabetes classes, food pantries, local Medicaid office, etc.?

- ☐ Yes
- ☐ No, provide member/caregiver with a list of resources and contact numbers.

Comments:

38. If the member/caregiver is not aware of where to go for services within the community, select from below, the resources that been provided to the member.

- ☐ Clothing assistance
- ☐ Disease specific association(s)
- ☐ Food pantries
- ☐ Gym
- ☐ Heating assistance
- ☐ Housing assistance
- ☐ Interpreter Services
- ☐ Smoking cessation
- ☐ Support groups
- ☐ Waivers
- ☐ Other

Comments:

Initial Assessment — Adults

39. What do you see as the member's/caregiver's barriers to following the treatment and/or self-management plan? Select all that apply

- ☐ Communication skills
- ☐ Cultural
- ☐ Difficulty obtaining medications
- ☐ Do not believe participation will improve health
- ☐ Don't know what I need
- ☐ Environmental
- ☐ Financial
- ☐ Geographic
- ☐ Hearing Impairment
- ☐ Lack of caregiver support
- ☐ Lack of DME supplies
- ☐ Lack of knowledge- condition
- ☐ Lack of knowledge- diet
- ☐ Lack of knowledge- disease
- ☐ Lack of knowledge- medications
- ☐ Lack of knowledge- medications benefits
- ☐ Lack of knowledge- transportation benefits
- ☐ Lack of knowledge- transportation
- ☐ Lack of knowledge- physical health benefits
- ☐ Lack of knowledge- mental health benefits
- ☐ Lack of physical exercise
- ☐ Lack of support from family
- ☐ Language
- ☐ Lifestyle Choices
- ☐ No available/convenient par providers
- ☐ No barriers identified
- ☐ Over use of prescription drugs
- ☐ Primary Provider is not responsive
- ☐ Primary Provider's office hours
- ☐ Psychological Impairment
- ☐ Psychosocial factors
- ☐ Religious
- ☐ Specialist's office hours
- ☐ Use of Alcohol
- ☐ Use of Methadone
- ☐ Use of street drugs
- ☐ Use of tobacco
- ☐ Vision Impairment
- ☐ Other

Comments:

Initial Assessment — Adults

40. Does the member have an advance directive and /or healthcare surrogate or durable power of attorney?

- ☐ Yes
- ☐ No, provide member with resource on where to obtain Life Planning information

Comments:

41. Developmental Disability/Cognitive Impairment Assessment

- ☐ Alert/oriented
- ☐ Requires prompting
- ☐ Requires assistance and some direction
- ☐ Requires considerable assistance
- ☐ Totally dependent

Comments:

Initial Assessment — Adults

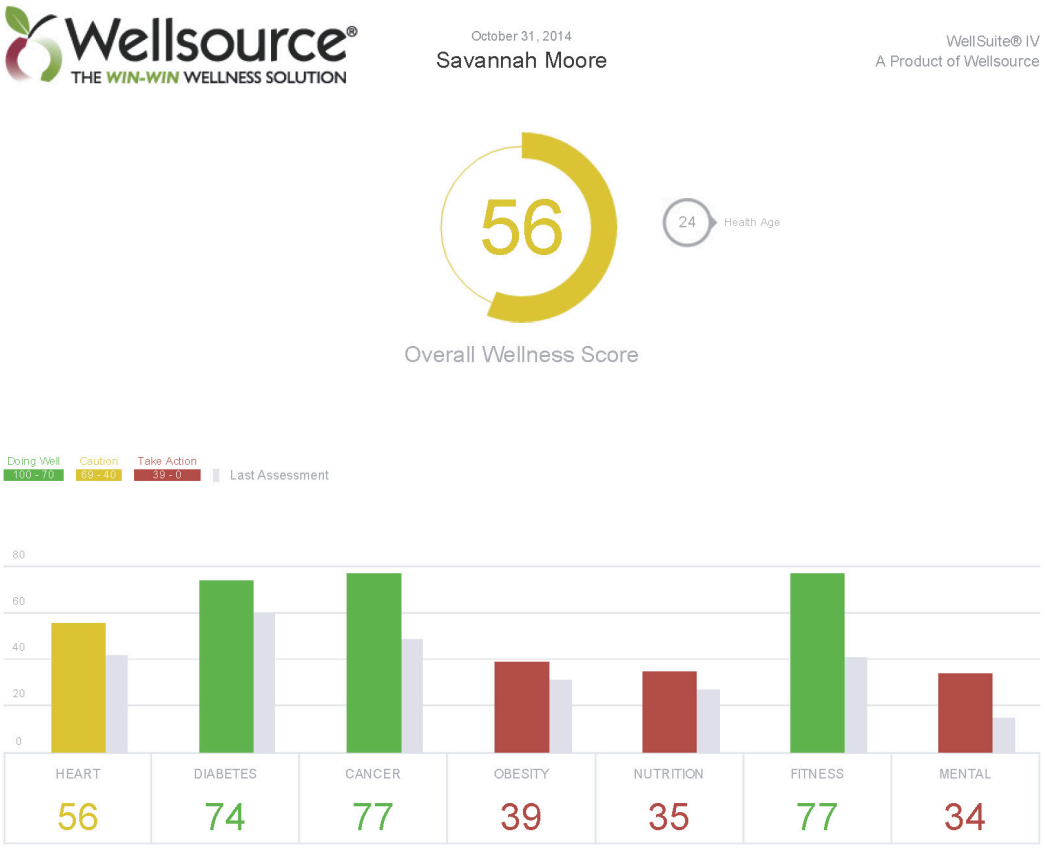
42. What goals does the member/caregiver have for the members self-management plan. Check all that apply. Enter the goal specified by the member/caregiver into the free text box.

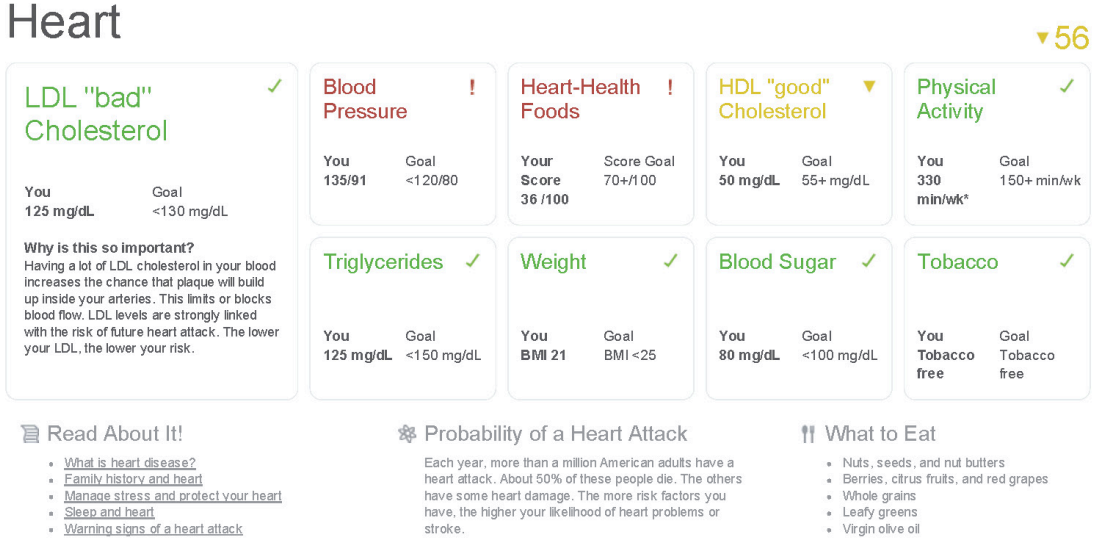
☐ Behavioral Health Needs	☐ DME	☐ Smoking Cessation
☐ Better Control of disease	☐ Electricity Assistance	☐ Transportation Assistance
☐ Care Coordination	☐ Housing Assistance	☐ Waiver Assistance
☐ Caregiver needs	☐ Legal Needs	☐ Weight gain
☐ Diet/ Nutrition	☐ Medication Assistance	☐ Weight loss
☐ Disease knowledge	☐ Resources	☐ Other

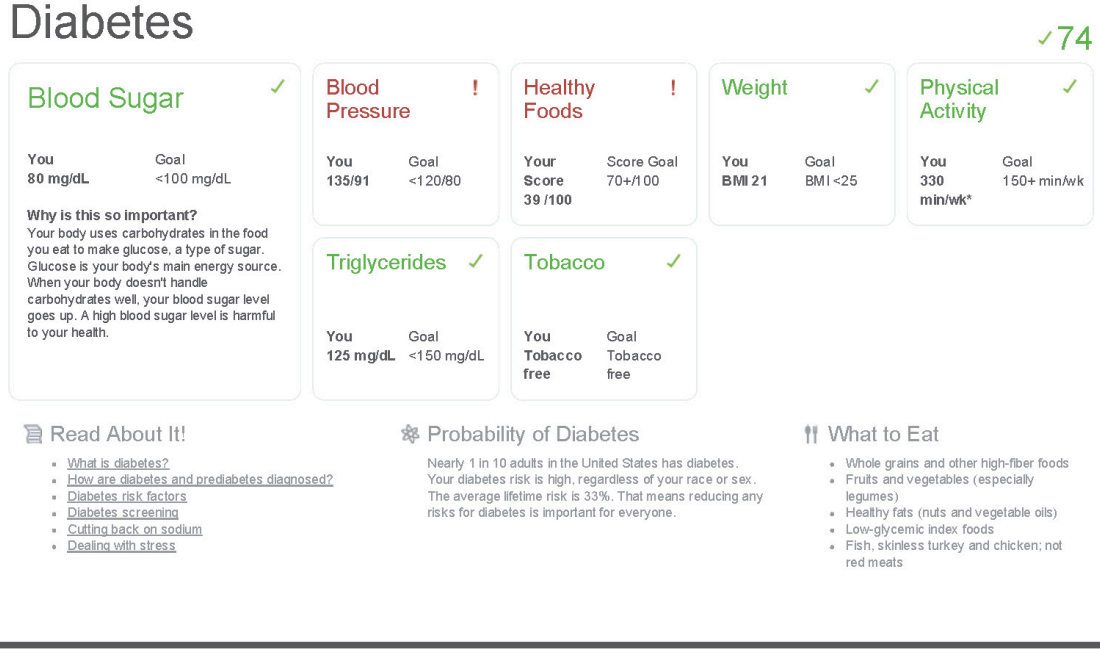
Comments:

Attachment 9.1.6-A: Example Care Plans

Wellness, prevention and low-risk care plan: example/subset




Heart
▼56
LDL "bad" Cholesterol
✓
You
125 mg/dL
Goal
<130 mg/dL
Why is this so important?
Having a lot of LDL cholesterol in your blood increases the chance that plaque will build up inside your arteries. This limits or blocks blood flow. LDL levels are strongly linked with the risk of future heart attack. The lower your LDL, the lower your risk.
Blood Pressure
!
You
135/91
Goal
<120/80
Heart-Health Foods
!
Your Score
36 /100
Score Goal
70+/100
HDL "good" Cholesterol
▼
You
50 mg/dL
Goal
55+ mg/dL
Physical Activity
✓
You
330 min/wk*
Goal
150+ min/wk
Triglycerides
✓
You
125 mg/dL
Goal
<150 mg/dL
Weight
✓
You
BMI 21
Goal
BMI <25
Blood Sugar
✓
You
80 mg/dL
Goal
<100 mg/dL
Tobacco
✓
You
Tobacco free
Goal
Tobacco free
Read About It!
What is heart disease?
Family history and heart
Manage stress and protect your heart
Sleep and heart
Warning signs of a heart attack
Probability of a Heart Attack
Each year, more than a million American adults have a heart attack. About 50% of these people die. The others have some heart damage. The more risk factors you have, the higher your likelihood of heart problems or stroke.
What to Eat
Nuts, seeds, and nut butters
Berries, citrus fruits, and red grapes
Whole grains
Leafy greens
Virgin olive oil


Diabetes
✓74
Blood Sugar
✓
You
80 mg/dL
Goal
<100 mg/dL
Why is this so important?
Your body uses carbohydrates in the food you eat to make glucose, a type of sugar. Glucose is your body's main energy source. When your body doesn't handle carbohydrates well, your blood sugar level goes up. A high blood sugar level is harmful to your health.
Blood Pressure
!
You
135/91
Goal
<120/80
Healthy Foods
!
Your Score
39 /100
Score Goal
70+/100
Weight
✓
You
BMI 21
Goal
BMI <25
Physical Activity
✓
You
330 min/wk*
Goal
150+ min/wk
Triglycerides
✓
You
125 mg/dL
Goal
<150 mg/dL
Tobacco
✓
You
Tobacco free
Goal
Tobacco free
Read About It!
What is diabetes?
How are diabetes and prediabetes diagnosed?
Diabetes risk factors
Diabetes screening
Cutting back on sodium
Dealing with stress
Probability of Diabetes
Nearly 1 in 10 adults in the United States has diabetes. Your diabetes risk is high, regardless of your race or sex. The average lifetime risk is 33%. That means reducing any risks for diabetes is important for everyone.
What to Eat
Whole grains and other high-fiber foods
Fruits and vegetables (especially legumes)
Healthy fats (nuts and vegetable oils)
Low-glycemic index foods
Fish, skinless turkey and chicken; not red meats

Complex care management member/Medicaid complex member

Cindy is a 45-year-old female with a history of diabetes, hypertension and depression. She has an open wound on her left lower leg that has not healed despite daily dressings for the last 9 months. A widow, Cindy lives with her daughter who works full-time. Cindy had three inpatient admissions in the last year, two related to her diabetes and one as the result of a fall. According to her prescription fill history, Cindy takes 20 different medications and often has gaps in filling her maintenance medications. Her last HbgA1c was 9.5 percent and her LDL-C was 96 mg/dl. Cindy's plan of care contains a member centered self-management plan and a care manager care plan:

Member Centered Self-Management Care Plan				
Problems	**Category**	**Goals**	**Activities**	**Additional Services**
1. Achieve optimum self-management (member's self-management plan)	Complex Medicaid	• Create a Safety Plan —High Priority Goal. • Manage condition by following treatment plan. • Improve ADL's/ functionality.	a. Fall risk plan b. Medication safety plan. c. Refill medications. d. Check for irregularities regarding skin condition. e. Change wound dressing as directed. f. Appropriate use of PCP/urgent care/ER. g. Follow disease specific diet. h. Remove potential fall hazards from the home environment. i. Identify limitations.	• Home evaluation. • Medication reconciliation with pharmacy. • Nutritional assessment.

Member Centered Self-Management Care Plan				
2. Ability to develop and maintain self-management (care manager's plan of care).	Complex Medicaid	• Member/caregiver will obtain optimum level of health by participating in self-management of condition(s) — High Priority Goal.	a. Self-management plan developed and communicated with member/ caregiver by phone. b. Assess and evaluate caregiver's resources and level of involvement. c. Assess for medication adherence, including understanding of medications and frequency. d. Assess member's understanding of how and when to contact PCP/urgent care/ER. e. Contact PCP/SCP to review treatment plan. f. Develop a member/caregiver self-management plan with member/caregiver involvement and assess progress towards goals. g. Educate on signs and symptoms of condition to report to provider. h. Monitor member's utilization. i. Utilize MI techniques. j. Follow/coordinate with CCMT	• Medication reconciliation with claims and pharmacy. • Obtain treatment plan from PCP/specialist. • Refer member to CCMT for face-to-face visit at PCP and home.

Complex member who qualifies for waiver services in the community

George is a 55-year-old male with a history of hypertension and a recent stroke, resulting in left leg and arm paralysis. George is married and lives with his wife who never worked. The couple often does not have food in their apartment and they were recently without heat or hot water. George takes four medications. His plan of care contains a member centered self-management plan and a care manager care plan:

Member Centered Self-Management Care Plan				
Problems	**Category**	**Goals**	**Activities**	**Additional Services**
1. Achieve optimum self-management (member's self-management plan).	Complex Medicaid	• Create a safety plan. • Meet basic needs — High Priority Goal. • Improve ADL's/functionality.	a. Fall risk plan. b. Apply for fuel/heating assistance. c. Contact food pantries. d. Contact resources for utilities. e. Remove potential fall hazards from the home environment. f. Identify limitations. g. Contact waiver services.	• Home evaluation. • Nutritional assessment. • Contact local trustee. • Contact local food pantries. • Contact with Iowa HCBS Waiver for Persons with Physical Disabilities.
2. Ability to develop and maintain self-management (care manager's plan of care).	Complex Medicaid	• Member/caregiver will obtain optimum level of health by participating in self-management of condition(s) — High Priority Goal.	a. Self-management plan developed and communicated with member/caregiver by phone. b. Assess and evaluate caregiver's resources and level of involvement. c. Assess for medication adherence, including understanding of medications and frequency. d. Contact PCP/specialist to review treatment plan. e. Educate on signs and symptoms of condition to report to provider. f. Utilize MI techniques. g. Assess barriers to care and self-management. h. Assist with identifying appropriate resources. i. Follow up on recommended resources.	• Respite care under Iowa HCBS Health and Disability Waiver. • Local resources for heat and food.

Complex member who lives in a residential placement setting — Developmental delay

Kathy is a 24-year-old female with a history of spinal bifida, obesity and depression. Kathy lives in a boarding home and feels isolated from her community. Her plan of care contains a member centered self-management plan and a care manager care plan:

Member Centered Self-Management Care Plan				
Problems	**Category**	**Goals**	**Activities**	**Additional Services**
1. Achieve optimum self-management (member's self-management plan).	LTSS	• Get involved in social/ recreational activities —High Priority Goal. • Develop 1–2 healthier lifestyle choices in the next 3–6 months.	a. Volunteer in the community. b. Attend religious services/programs/ church ministries. c. Avoid high sugar drinks. d. Drink more water.	• Iowa HCBS Intellectual Disabilities wavier for transportation services. • Nutritionist.
2. Ability to develop and maintain self-management (care manager's plan of care).	LTSS	• Member/caregiver will obtain optimum level of health by participating in self-management of condition(s) — High Priority Goal.	a. Self-management plan developed and communicated with member/caregiver by phone. b. Assess and evaluate member/caregiver's readiness to change. c. Assess member's weight gain or loss. d. Develop a member/caregiver self-management plan with member/caregiver involvement and assess progress towards goals. e. Encourage health-promoting behaviors. f. Follow up on recommended resources. g. Utilize MI techniques. h. Discuss available therapy/behavioral health intervention.	• Connect to Nutritionist. • Connect to behavioral health services.

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10. Quality Management and Improvement Strategies

Please explain how you propose to execute Section 10 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Overview

AmeriHealth Caritas Iowa will implement a Quality Management/Quality Improvement (QM/QI) program incorporating a robust set of measurable objectives, provider and member incentives and quality improvement activities that are designed to improve the delivery of healthcare services across the care continuum for all of our members. We proudly bring over 30 years of expertise and leadership in managed Medicaid programs, delivering high-quality care and positive health outcomes in all the markets we serve.

AmeriHealth Caritas' core focus on access, quality and affordability of care is rooted in over 30 years of high-quality performance and success in improving outcomes.

Our focus empowers us to lead the next generation of healthcare delivery — and to realize Governor Branstad's vision for Iowa being the healthiest state in the country.

The AmeriHealth Caritas Iowa quality team will reside in Iowa, with corporate support for data analytic functions. Our data driven approach in Iowa will include the identification of baseline quality outcomes results and the implementation of creative strategies to improve upon them. Those strategies include the use of member and provider incentives to address both physical and behavioral health outcomes.

All AmeriHealth Caritas Family of Companies (AmeriHealth Caritas) health plans undergo National Committee for Quality Assurance (NCQA) accreditation. All AmeriHealth Caritas health plans eligible to receive an accreditation level are currently rated Commendable. Three AmeriHealth Caritas plans have Interim Accreditation, which is the NCQA accreditation available to new health plans. All three interim accredited plans are undergoing full accreditation reviews this year. Additionally, our plans in Pennsylvania and South Carolina are also recognized by NCQA as having their Multicultural Health Care certification and are inaugural participants in NCQA's voluntary Multicultural Health Care Distinction program.

AmeriHealth Caritas has a strong history of collaboration with States and local governments to customize quality assessment/performance improvement (QAPI) program offerings to support specific quality goals and objectives. Our staff recognizes the QAPI program as critical to all aspects of clinical care and service. Our deep commitment to strategic and tactical innovations gives us the flexibility and scalability to tailor current best practices, and design new processes or leverage new technologies, to become best solutions.

AmeriHealth Caritas Iowa will comply with all needs stated within this section, including areas not specifically addressed in the questions below.

10.1 Contractor Quality Management/Quality Improvement Program

1. Describe your Quality Management and Improvement Program, addressing all elements outlined in Section 10.1.2. Include how you will monitor, evaluate and

take effective action to identify and address any needed improvements in the quality of care delivered to members.

Program requirements

The AmeriHealth Caritas Iowa Quality Assessment Performance Improvement (QAPI) program meets all requirements of 42 CFR 438 subpart D and NCQA accreditation standards. NCQA is the credentialing body by which all AmeriHealth Caritas health plans are credentialed. Our QAPI program descriptions, as in all the other States we operate, will be developed exclusive to Iowa and shall not contain documentation from other State Medicaid programs or other AmeriHealth Caritas markets.

Our QAPI program integrates knowledge, structure and processes throughout the healthcare delivery system to assess risk and to improve quality and safety of clinical care and services provided to members. The QAPI program provides the infrastructure to systematically monitor, objectively evaluate and ultimately improve the quality, appropriateness, efficiency, effectiveness and safety of the care and service provided to AmeriHealth Caritas members.

Our QAPI program is designed to monitor and evaluate the quality of care and service provided to members. QAPI program activities are conducted using the plan-do-check-act (PDCA) methodology:

1. Plan — Establish objectives and processes necessary to meet performance or outcome goals.
2. Do — Implement the plan and processes; collect data for further analysis.
3. Check — Evaluate and compare the results to the performance/outcome goal; identify differences between the actual/expected/target outcomes.
4. Act — Develop and implement corrective action to address significant differences between the actual and planned results; conduct root cause analysis; as necessary, return to the Plan step.

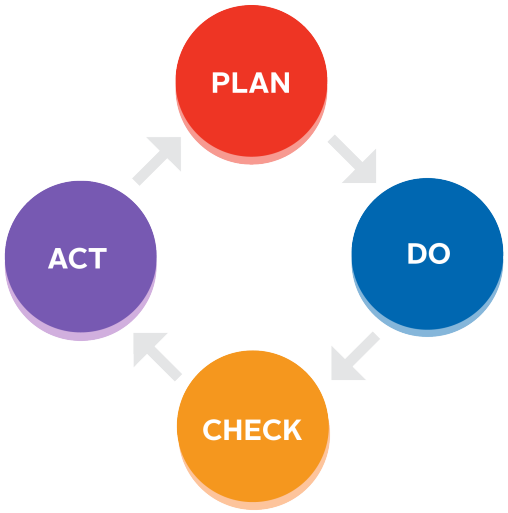


Exhibit 10.1-A: PDCA Quality Process

Program availability

The AmeriHealth Caritas Iowa QAPI program will be submitted to the Iowa Department of Human Services (DHS) for review and approval at the start of the contract period. The full contents of the QAPI program, and the annual program evaluation, will be available to members and providers on the respective AmeriHealth Caritas Iowa member and provider portal sites. In addition, AmeriHealth Caritas Iowa will produce an easy-to-read *Report to the Community* to communicate key outcomes of AmeriHealth Caritas Iowa's programs.

QAPI work plan

AmeriHealth Caritas Iowa will develop an annual work plan and prospective five-year QAPI work plan, as required by the State, which sets measurable goals, establishes objectives and identifies strategies and activities to be undertaken. The work plan will form the basis for QAPI interventions and monitoring

activities throughout the year. The work plan is updated monthly and reviewed quarterly at the QAPI committee meeting.

Quality resources

The Quality Assessment Performance Improvement Committee (QAPIC), AmeriHealth Caritas Iowa's medical director, behavioral health director and manager of quality management collectively have responsibility for planning, designing, implementing and coordinating quality improvement activities.

Key QAPI roles supporting quality management activities for AmeriHealth Caritas Iowa are described below:

A. Medical director — Designated Iowa-licensed physician responsible for the medical leadership, oversight and implementation of the QAPI program; serves as the chairperson of the QAPIC.

B. Medical director, behavioral health — Designated Iowa-licensed behavioral health physician who supports the provision of quality and clinically sound behavioral health and system of care services to all individuals in the system of care.

C. Director of Quality Management — Provides leadership and direction for the QAPI program; responsible for the day-to-day activities and staff associated with quality activities, accreditation, QAPI work plan implementation and program evaluation.

D. Manager, medical economics — Provides oversight of Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) and other QAPI-related data collection and analysis, including reports and analysis to support utilization pattern identification and health outcome improvement.

E. Quality management nurse — Provides clinical review for potential quality of care concerns; assists with QAPI data collection and implementation of QAPI initiatives.

F. Quality performance management specialist — Assists with QAPI data collection and implementation of QAPI initiatives

G. CLAS coordinator — Assists with incorporation of Culturally and Linguistically Appropriate Services (CLAS) standards into quality activities and focused analysis and activity development to address health disparities.

H. Clinical auditor/trainer — Provides education to physician offices on clinical guidelines and condition management in support of behavioral health integration and AmeriHealth Caritas Iowa's QAPI goals.

I. Additional Resources — QAPI activities are supported by leadership and staff roles across the organization, including Integrated Healthcare Management (IHM; includes care management, behavioral health management, long term services and support, rapid response), utilization management, network management, service operations and member services.

The number of resources involved in the QAPI program in Iowa is consistent with staffing in AmeriHealth Caritas' other plans. The adequacy of our staffing will be assessed and adjustments will be made as needed throughout the year to support program goals.

Program scope

The scope of the QAPI program encompasses processes to promote access and availability of healthcare services, activities to improve health outcomes and initiatives to improve satisfaction for members and providers across the physical health, behavioral health and long-term services and supports (LTSS)

domains. The QAPI program is implemented using a comprehensive and integrated systematic process of collecting information, analyzing the information, identifying opportunities to improve care and service, acting upon such opportunities and monitoring the effectiveness of interventions.

The scope of the QAPI program includes the following areas:

- Identification of the member profile.
- Monitoring accessibility and availability of care.
- Assessment of quality of care across the spectrum of healthcare delivery.
- Member, provider and practitioner satisfaction.
- Member grievance and appeal processes and trends.
- Maternity, chronic condition, behavioral health and LTSS improvement initiatives.
- Development, implementation and adherence assessment of clinical and preventive health practice guidelines.
- Member safety.
- Clinical quality initiatives.
- Review of quality of care concerns.
- Assessment of care coordination and continuity of care.
- Monitoring of utilization, including over-, under- and mis-utilization.
- Monitoring of practice pattern variation and identification of outliers.
- Monitoring prescribing patterns for clinical guideline concordance and identification of outlier patterns.
- Assessment of quality of health plan service.
- Credentialing/re-credentialing activities.
- Preventive healthcare services.
- Medical record documentation.
- Oversight of delegated activities.
- Activities to reduce healthcare disparities.
- Activities to improve linguistic and cultural competence.
- Additional performance measurement required by the Centers for Medicare & Medicaid Services (CMS) or DHS.

Practice pattern analysis

Through QAPI program activities, AmeriHealth Caritas Iowa will analyze practice patterns to identify over-utilization, under-utilization, potential mis-utilization and any variation from AmeriHealth Caritas Iowa's clinical practice guidelines. Standard activities in the QAPI work plan include:

Over- and under-utilization identification and targeted intervention — Ongoing analysis is conducted for a number of procedures and services relevant to the AmeriHealth Caritas Iowa population that are prone to over- or under-utilization. AmeriHealth Caritas Iowa will have access to aggregate utilization data from other AmeriHealth Caritas plans and is able to use internal benchmark data, as well as externally published data from similar Medicaid populations to determine if over-utilization of resources is occurring. AmeriHealth Caritas Iowa will risk-adjust data to ensure that populations can be fairly compared. AmeriHealth Caritas health plans have sufficient membership across multiple States, to allow the establishment of reliable benchmarks for Iowa membership.

Over-utilization example: Positron Emission Tomography (PET) scans

Ongoing monitoring of high-level imaging studies identified a significant variation in utilization of PET scans across several AmeriHealth Caritas health plans. Utilization outliers were present even when the results were controlled for population mix and access to PET scan technology. As a result, AmeriHealth Caritas developed and implemented an evidence-based clinical policy for use in reviewing all requests for this technology. Following implementation of the policy, utilization in the highest utilizing State was reduced to the utilization rate observed in other AmeriHealth Caritas markets.

Under-utilization example: laboratory testing

We recognize that laboratory test results drive many healthcare decisions, but the process in obtaining the results can be scary, intimidating, inconvenient and expensive. It's estimated that between 40-60 percent of laboratory tests are not completed, which means that individuals and their healthcare providers likely don't have all the right information at the right time to make important healthcare decisions or develop comprehensive care plans. Theranos' revolutionary lab service platform uses dramatically smaller samples than traditional labs, with samples collected from both capillary draws and traditional methods. Results are returned much faster than industry averages, with the overwhelming majority of results reported within 24 hours of sample collection. Our strategic partnership with Theranos provides an opportunity for us to quickly, and more actively, engage all new members in Iowa in their overall health and wellness.

Under-utilization example: management of hyperlipidemia

When the 2013 American College of Cardiology/American Heart Association updated practice recommendations for the management of hyperlipidemia were adopted by AmeriHealth Caritas health plans, an analysis of statin utilization (including dosage prescribed) was conducted for members with diabetes, documented cardiac disease and hyperlipidemia. Results indicated under-utilization of statin medication for at-risk members. In response, AmeriHealth Caritas developed a continuing medical education (CME) program for network providers and implemented it across all plans to educate physicians on the new recommendations and provided member-specific information to physicians for review and action. Rates have increased across all plans.

Clinical practice guideline adherence — Guidelines selected for adherence measurement are identified by the QAPIC and noted on the annual QAPI work plan. Statistical sampling methodology is used to identify the number of practitioners reviewed. Results are reported as an aggregate rate for the network and at the individual practitioner level. Based on results, educational initiatives are designed to reinforce guideline recommendations with the network as a whole and/or provide education or technical support to individual practitioners. At the direction of the QAPIC, key clinical practice guideline metrics are added to the physician quality incentive program to bolster visibility and adherence.

AmeriHealth Caritas Iowa's Medical Economics team will be able to provide detailed information on macro trends of utilization and also will have the capability to study variations in care at the community or at the practice level. This capability is consistent with the field of small area variation analysis.

Prescribing patterns — Medication prescribing history is continually analyzed to identify patterns that deviate from current clinical practice guidelines and/or indicate a potential over- or under-utilization of

medication. Based on the outcome of the analysis, the medical director and quality team design and implement appropriate initiatives.

Prescribing pattern examples:

Insulin use

Physicians treating diabetic members prescribed two or more oral hypoglycemic medications are contacted and educated on the clinical evidence supporting the use of insulin as a third-line therapy for diabetes control. Providers are encouraged to consider adding basal insulin for members to improve HgbA1c control. Our plan with the highest number of diabetic numbers saw a statistically significant increase in the adoption rate of basal insulin among the identified members. Initially started as a pilot program, this process is now part of our standard care gap identification and physician education strategy.

Suboxone prescribing

AmeriHealth Caritas is currently participating in the Association of Affiliated Community Plans (ACAP) collaborative on substance abuse. Our initiative was developed following analysis of suboxone prescribing patterns. As a result of wide variation in prescribing practice and definite variation from suboxone prescribing guidelines, AmeriHealth Caritas initiated a process to limit the ability to prescribe suboxone for our members to a limited network of physicians who met best practice criteria.

Controlled substance use

In several of our health plans, AmeriHealth Caritas also implements State-approved programs to restrict members receiving numerous controlled substance prescriptions, and/or controlled substance prescriptions from multiple prescribing physicians to one physician prescriber, and in some cases to one pharmacy. This ensures that the physician prescribing the medication is aware of all of the other controlled substance prescriptions the member received. Members are identified through analysis if pharmacy data. Prescription events are also correlated to emergency room (ER) events, as members often use the ER as the avenue to obtain a new prescription from a physician who may not be aware of the member's history. The review is conducted in the context of the member's clinical history. Once potential overuse of controlled substances is identified, the Care Management team initiates outreach to engage the member in care management and notify him/her of the planned restriction. The member has the right to appeal the restriction decision.

Aripiprazole (Abilify) use in children

Analysis of pharmacy data revealed that aripiprazole was the most frequently prescribed psychotropic medication and that it was being used outside of the American Academy of Pediatrics (AAP) guidance. As a result of the analysis, AmeriHealth Caritas plans provide educational material on the AAP guidelines to prescribing physicians and has placed edits related to age and prior medication use to reduce the inappropriate prescribing of this drug.

Treatment effectiveness

AmeriHealth Caritas Iowa will use industry-standard measures of functional status, including the SF-12 Patient Questionnaire (SF12), to measure effectiveness of treatment services. Additionally, the plan will solicit input from practicing physicians to improve effectiveness, as shown in the following example:

Example: treatment service effectiveness

AmeriHealth Caritas Iowa's affiliate in Pennsylvania had a network physician who was concerned that patients in treatment for substance abuse were not being appropriately monitored for concurrent opiate use through the collection of blood or urine. He proposed that the health plan cover salivary testing as a way to reduce "gaming" or errors inherent in blood and urine collection. An evidence-based review was conducted, which led to the addition of salivary testing (but not hair or skin cell testing) to its coverage guidelines for testing members in drug maintenance programs

Written policies

AmeriHealth Caritas Iowa's QAPI program is supported by a detailed program description document and a comprehensive set of written policies. Program policies include sections outlining AmeriHealth Caritas Iowa's policy on the topic, the procedure and method used to implement the policy, timelines for procedure steps, as applicable, and the individuals responsible for the task. Policies are reviewed at least annually and revised as needed.

Monitoring and improving services

AmeriHealth Caritas Iowa's QAPI program will use a comprehensive set of data to monitor and improve the delivery of physical health, behavioral health, LTSS and related health outcomes. Segmental analysis is performed for identified subpopulations including pregnant women, members with serious persistent mental illness, members eligible for/receiving LTSS, members with developmental disabilities and children in foster care/residential placement or other identified special needs. Some of the data sets used include:

- Access and availability data.
- CAHPS results.
- Participant experience survey (HCBS) results.
- Medical, behavioral health and LTSS claim data.
- Clinical guideline performance studies.
- CLAS data.
- Focused reviews.
- Health risk assessment data and screening responses.
- HEDIS and other metrics defined by DHS.
- Member dissatisfaction data.
- Member opt-out data.
- Medical record reviews.
- Performance improvement project/outcome study analysis.
- Pharmacy utilization data.
- Provider and practitioner satisfaction survey results.

- Physician office medical record reviews.
- Quality indicator studies.
- Sentinel condition analysis.
- Utilization data.
- Treo Solutions' 3M Clinical Risk Grouper (CRG) and Value Index Score (VIS) data.
- State or CMS specific requirements.

Developing performance improvement projects

The results of data collection and analysis will be reviewed by AmeriHealth Caritas Iowa's clinical leadership team, led by the AmeriHealth Caritas Iowa medical director. The QAPI committee will assist with prioritization of opportunities and actions. Performance improvement projects (PIPs) will be developed to address areas of concern or low performance, both clinical and service-related, identified through internal analysis and external recommendations. Prioritized projects will include opportunities to improve physical health, behavioral health and long-term care. AmeriHealth Caritas Iowa will monitor, evaluate and improve the quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to members through peer review, performance improvement plans (PIPs), medical record audits, performance measures, surveys and related activities.

Additionally, AmeriHealth Caritas Iowa will have access to AmeriHealth Caritas' extensive clinical policy development activities so that strategies can be designed to promote evidence-based practice patterns in Iowa that are consistent with those guidelines. AmeriHealth Caritas has published more than 150 clinical policies, and made them available to both members and providers on our public websites. Clinical policies help to improve quality by reducing inappropriate over-utilization. For example, some very frequently requested surgical procedures can have significant complication rates, such as with bariatric surgery and supraglottoplasty. Clinical policies help ensure that these surgical procedures are being performed for individuals for whom the evidence shows that the benefits from the surgery outweigh the risks. Our clinical policy on testing for drug abuse assisted in reducing the under-utilization of testing for patients in substance abuse treatment in several of our markets.

Re-measurement periods are built into the design of all performance improvement plans (PIPs) to allow for systematic and periodic follow up on the effect of the interventions. Goals are set to reflect demonstrable improvement, and/or achievement of benchmark performance, in the targeted health outcome or service.

Assessing performance

The quality indicators used to assess performance are based on accepted industry measures to allow for comparison with external benchmarks and consistency in evaluation across time periods. Wherever possible, nationally published specifications, such as HEDIS, CAHPS and events/1000, are used to measure changes in health outcomes, service levels, functional status and satisfaction associated with a PIP.

Evaluation and reporting

PIPs are monitored and evaluated according to the re-measurement schedule developed as part of the PIP design. Wherever possible, the same methodology is used to evaluate the program as was used for the baseline measurement. On rare occasions the metrics are altered in response to a change in national specifications, such as a HEDIS measure or CAHPS question.

The results of re-measurements are compared to the PIP goal and the identified benchmark. In addition to looking at trends, statistical significance is measured using a t-test or other appropriate statistical vehicle.

The analysis includes identification of barriers that impacted the interventions. Wherever possible, strategies are designed to address identified barriers in the next measurement cycle.

The QAPIC reviews the prioritization, plans and results of quality improvement activities and projects. PIP results are also reported to the Iowa Department of Public Health (DPH) and Iowa DHS, as requested.

Measuring member and provider satisfaction

Member satisfaction is measured through the CAHPS survey. In addition, AmeriHealth Caritas Iowa will administer the Iowa Participant Experience Survey (PES) for members receiving home and community based services (HCBS). Provider satisfaction is measured through an annual practitioner/provider satisfaction survey administered to practitioners and organizational providers on AmeriHealth Caritas Iowa's behalf by a third-party vendor. AmeriHealth Caritas Iowa will complete planning for administration of the CAHPs and PES during the first contract year, for administration the following spring. AmeriHealth Caritas Iowa will complete a provider satisfaction study during the fall of the first contract year. The results, along with analysis and trends on dissatisfactions and member opt-outs, are reported to the QAPI for review and identification/prioritization of opportunities for improvement.

Promoting participant safety

The QAPI department is responsible for coordinating activities to promote member safety. Initiatives will focus on promoting member knowledge about medications, home safety and hospital safety. Members are screened for potential safety issues during the initial assessment.

Participant and provider dissatisfaction

Dissatisfactions or complaints/grievances from members and providers are investigated, responded to and trended. Trends and the results of investigations are reported to the QAPIC, which coordinates initiatives to address identified opportunities for improvement.

Cultural competency and healthcare equity

AmeriHealth Caritas Iowa will initiate a cultural competency plan to promote the delivery of services to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes, values, affirms and respects the worth of the individual members and protects and preserves the dignity of each. The plan will include mechanisms for assessment of culturally appropriate service delivery, evaluation of healthcare equity across subpopulations and interventions to address identified opportunities.

Activities to assess and promote cultural competency and healthcare equity include the following:

- Collect and analyze practitioner race/ethnicity and language data to determine if the network is responsive to the needs of the membership.
- Develop a plan to address network race/ethnicity and language gaps.
- Support practitioners in providing appropriate language services.
- Conduct baseline assessment of performance on chronic care and preventive care outcome measures by race and ethnicity subgroups; identify and prioritize opportunities to reduce disparities.

Availability and accessibility audits

Annually, compliance to access and availability standards are monitored to ensure that sufficient numbers of network practitioners and providers are available to meet member needs. An assessment is conducted to compare the type, number and location of network practitioners and providers to AmeriHealth Caritas Iowa's standards and to calculate the ratio of full-time equivalent physicians, paramedical and ancillary

heath personnel to members. Provider types assessed include inpatient hospitals, ambulatory surgical centers and LTSS providers. The Quality of Service Committee (QSC) evaluates the report and planned actions annually. Data from the report, including changes in physician ratios and any action taken, is reported to the Iowa Insurance Commissioner, as may be required.

AmeriHealth Caritas Iowa also conducts an annual assessment of primary care providers' (PCPs) compliance to appointment standards for routine, urgent and sick office visits. Results of the survey are reported to the QSC for review and recommendations.

Reporting and evaluation

QAPI program activity will be reported throughout the year to the QAPIC, with updates quarterly to the AmeriHealth Caritas Iowa board of directors. Activity and outcomes will be reported using internal tools in addition to the reporting tools and specifications required by the Iowa DPH and DHS.

The QAPI program is evaluated as needed and at least annually to measure its effectiveness. The evaluation assesses all aspects of the QAPI program, including clinical and service performance improvement projects, quality studies and activities and the rationale, methodology, results and subsequent improvement associated with each study, along with findings and data from external quality review activity. The evaluation includes recommendations for improvement in the QAPI program, proposes goals and objectives for the following year and identifies the resources needed to accomplish the proposed goals and objectives. The QAPI program is revised as needed throughout the year and reviewed/revised at least annually.

In our consistent effort for continual improvement and innovation, the QAPI evaluation is used to determine the QAPI program description and work plan adjustments for the following year.

Improving the quality of care delivered to members

For over 30 years, AmeriHealth Caritas has consistently improved clinical outcomes and the quality of care for the Medicaid population across many States. We constantly analyze a combination of utilization, cost and clinical outcome data to evolve programs and solutions in tandem with the changing landscape. This gives us a complete view of our impact on the member's health status, and the power to change accordingly. We compare members receiving the intervention with a control group, when possible, to evaluate the difference between populations. The example initiatives below highlight our experience in several of our markets.

Management of high-risk pregnancy

Children and women of childbearing age comprise a large percentage of the Medicaid population, and one of AmeriHealth Caritas' primary focuses is on improving performance on maternal-child health outcomes and pediatric preventive care. Pregnant members are automatically enrolled in AmeriHealth Caritas' comprehensive maternity management program, Bright Start®. We are implementing additional tools in the form of interactive mobile phone applications to provide additional support for the member during her pregnancy. Our Moms2B program takes our Bright Start approach one step further for our pregnant members who are at high risk for a preterm delivery.

AmeriHealth Caritas will implement Bright Start in Iowa (as further described in Section 8: Member Services of this response). Once AmeriHealth Caritas Iowa members are identified as pregnant, they will be automatically enrolled in the Bright Start program. The Bright Start program works to improve birth

outcomes and reduce the incidence of pregnancy-related complications through early prenatal education and intervention. The program uses the Institute for Clinical Systems Improvement (ICSI) guidelines for the treatment and management of an at-risk pregnancy.

AmeriHealth Caritas Iowa will also implement its Moms2B program, which focuses on reducing the incidence of premature and low-weight births through intensive case management services. Members are provided with cell phones for calling and texting appointment reminders and key pregnancy information and incentives to promote prenatal and post-partum care. The program engages high-risk pregnant members, providing a high-intensity program tailored to the individual needs of the high-risk member.

Example outcomes

Through the Bright Start program, AmeriHealth Caritas affiliates have improved performance with respect to the percent of pregnant women who receive frequent prenatal care visits (81 percent or more of expected prenatal visits), with all plans at least at the 50th NCQA percentile.

Getting early prenatal care is the first step toward a healthy, full-term delivery. Two of AmeriHealth Caritas' health plans perform above the NCQA Medicaid 75th percentile for this measure.

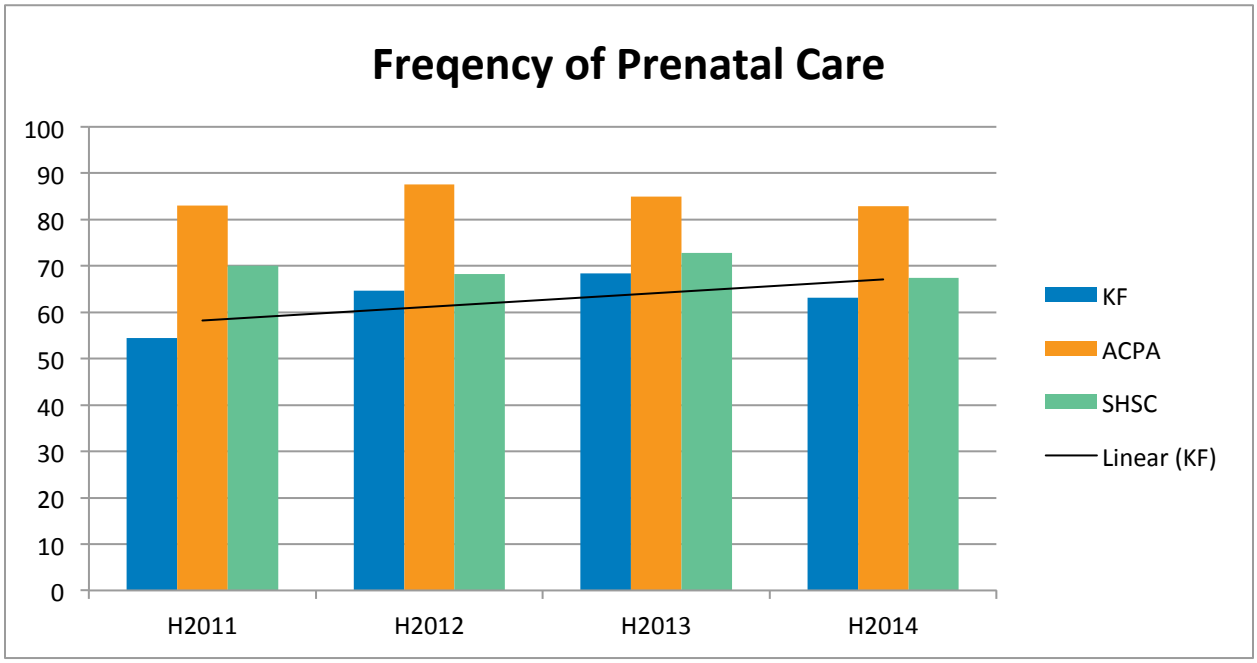


Exhibit 10.1-B: Frequency of Prenatal Care Outcomes

For the most recent enrollment cycle of the Moms2B program at AmeriHealth Caritas Iowa's Pennsylvania affiliate, 57 pregnant women at high risk for premature birth were enrolled. Forty-six of those high-risk pregnancies delivered a singleton birth with 39 of those infants weighing over 2,500 grams. Seven were considered low birth weight (between 1,500 and 2,500 grams) and none were in the very low birth weight (less than 1,500 grams) category. The average gestational age for this group was 37.2 weeks and the average birthweight was 6 pounds 7 ounces. Eight of the enrollees delivered twins, with an average gestational age of 34.8 weeks. Three have yet to deliver.

Reducing C-section rates

Additional outcomes associated with our work on maternal health include reductions in C-section rates and neonatal intensive care unit (NICU) length of stay. We continue to focus aggressively on decreasing the incidence of elective C-section deliveries in all of our markets. Our strategy includes eliminating the pricing differential between C-section and vaginal delivery reimbursement, partnering with obstetrical practices and promoting the March of Dimes "Wait for Labor" campaign. Market-specific examples of our partnership strategy are outlined below:

Market	Partnership Strategy
South Carolina	We actively participate in the State's birth outcome initiative and prohibit payment for elective C-sections prior to the 39th week of gestation.
Louisiana	We have worked with the March of Dimes to implement 17-P educational training with all OB providers. Web-based and onsite trainings focused on the appropriate use of 17-P and the initiative to reduce elective deliveries before the 39th week of gestation.
Nebraska	We work in conjunction with the Nebraska Medical Association and March of Dimes to support the implementation of hospital policies and review procedures to limit elective C-sections prior to 39 weeks to situations where the health of the mother or fetus is in jeopardy. Additionally, one of our largest provider groups, South East Rural Physicians Alliance Network (SERPA) ACO uses C-section rate as an internal quality indicator and they are incentivized for low prematurity rates.

Example outcomes

Results for our five largest health plans, displayed below, outline the percent change in C-section deliveries (2013 – 2014), with strong progress across our plans.

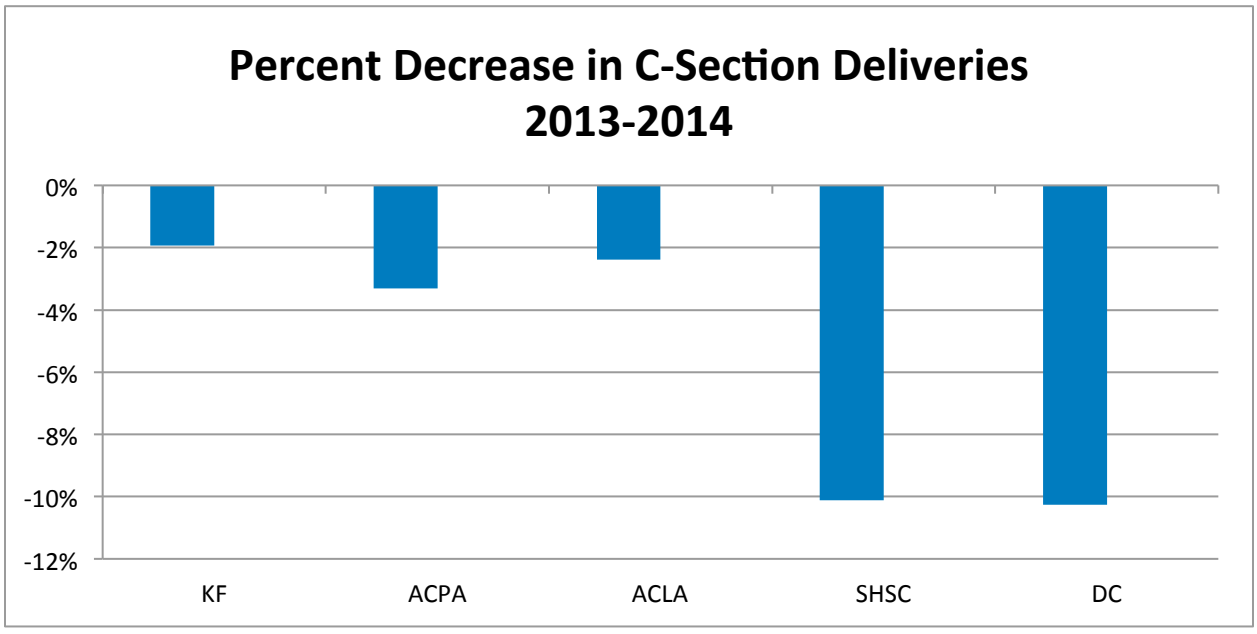


Exhibit 10.1-C: Percent Decrease in C-Section Deliveries (2013 – 2014)

EPSDT and pediatric preventive healthcare

Pediatric preventive care is another key focus for AmeriHealth Caritas. Our various programs have positively impacted EPSDT-related measures, including improvements in adolescent access, children's access and Immunization rates, as shown in the following graphics:

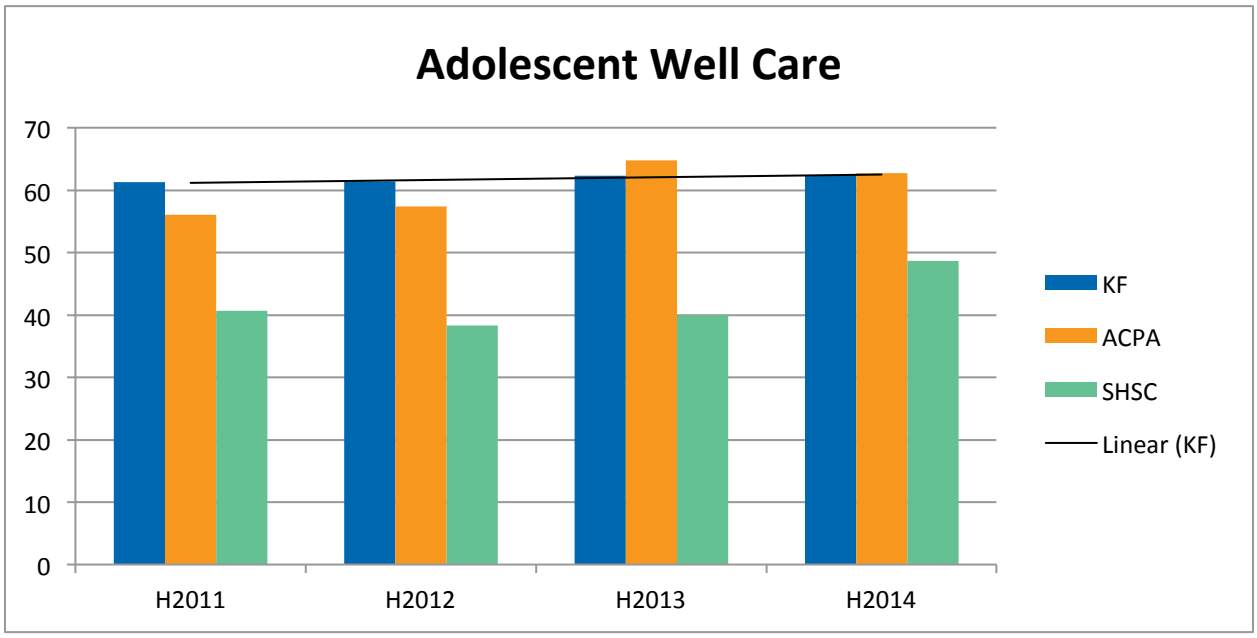


Exhibit 10.1-D: Adolescent Well-Care Access Outcomes — All three plans above Medicaid national average, with two plans in the 75th percentile

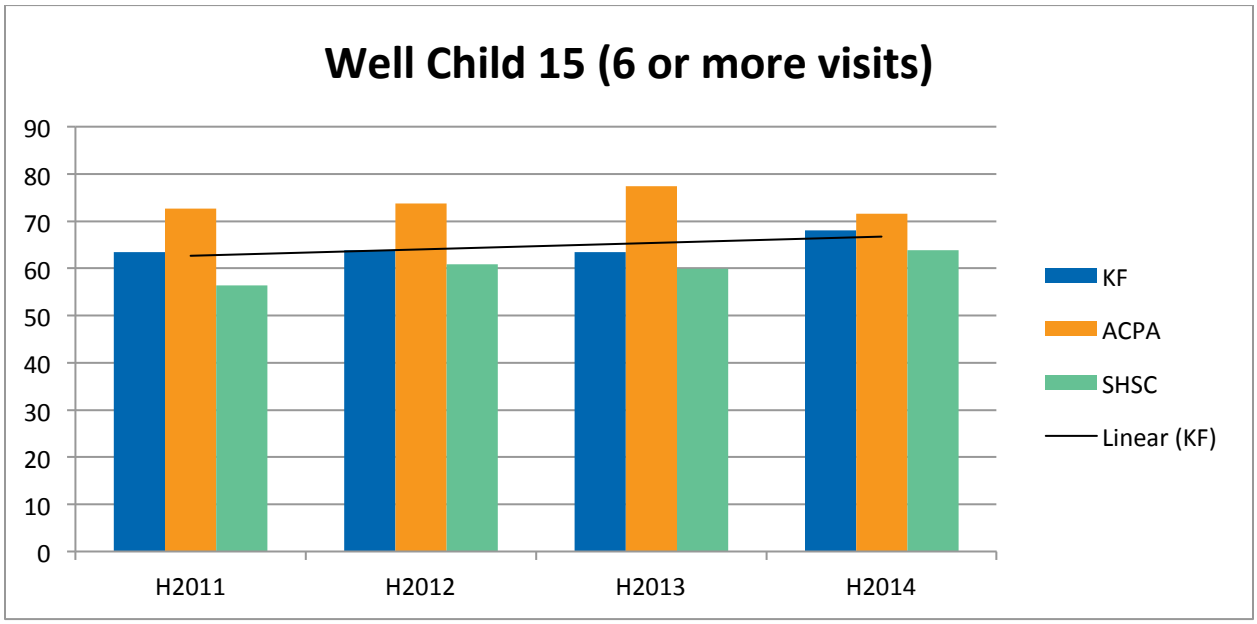


Exhibit 10.1-E: Well-Child 15 (6 or more visits) Outcomes — All three plans above Medicaid national average, with two plans in the 75th percentile

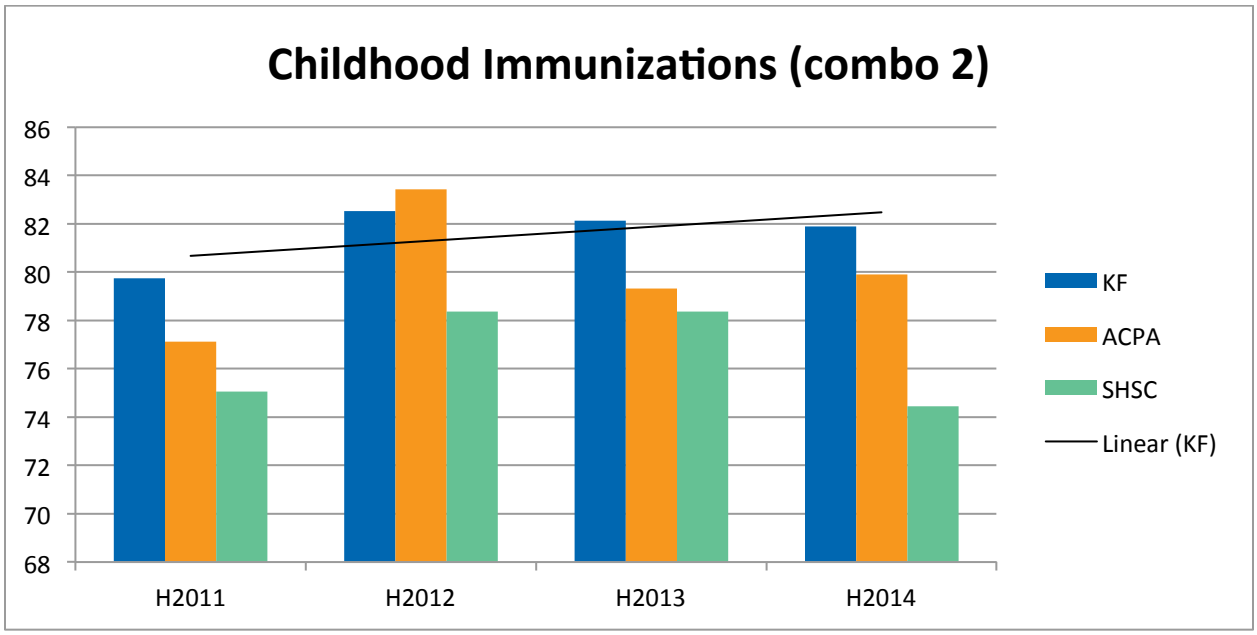


Exhibit 10.1-F: Childhood Immunizations Outcomes — All three plans above Medicaid national average, with two plans in the 75th percentile

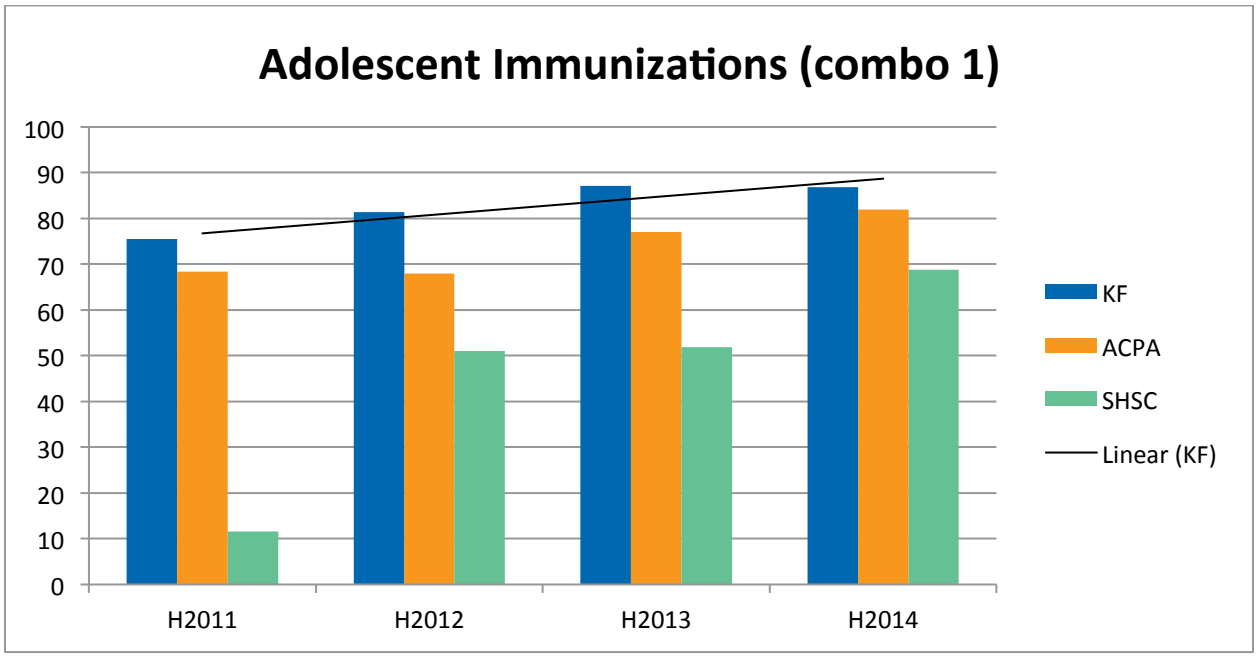


Exhibit 10.1-G: Adolescent Immunization Outcomes – Keystone First in 90th percentile, AmeriHealth Caritas Pennsylvania in the 75th percentile, Select Health showing strong progress

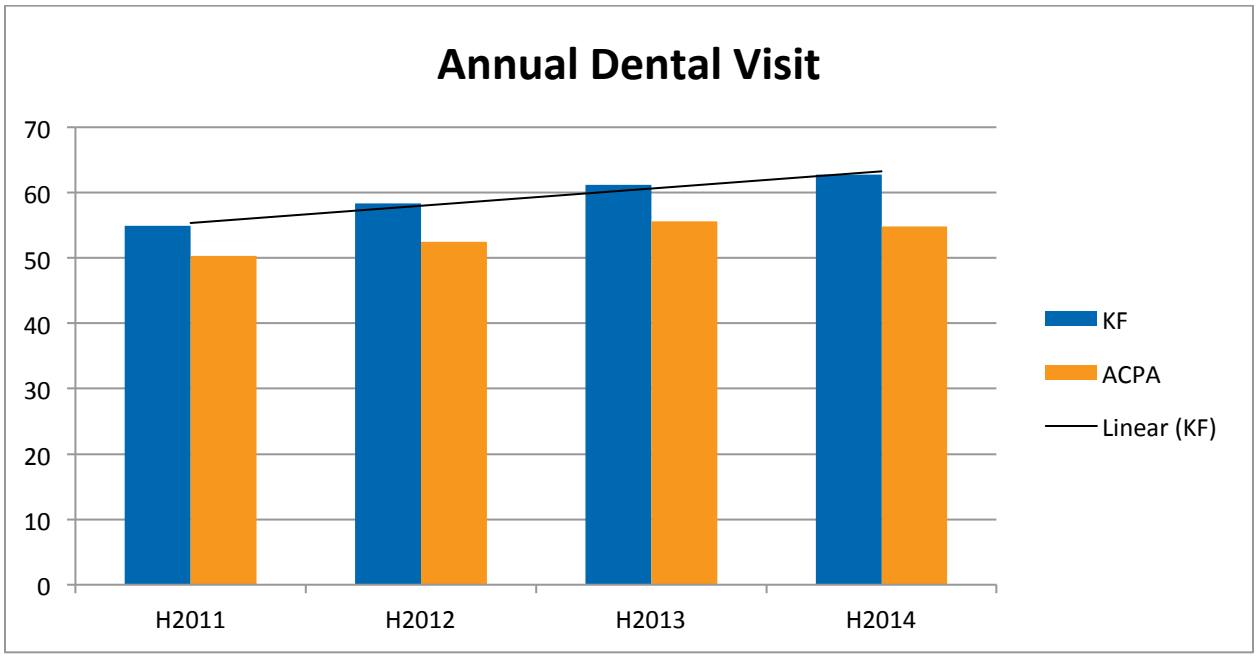


Exhibit 10.1-H: Dental visits (offered in AmeriHealth Caritas' PA plans), with one in 75th percentile; both in 50th percentile of Medicaid national average

2. Describe how you will utilize program data to support the development of the Quality Management and Improvement Work Plan.

AmeriHealth Caritas Iowa will analyze available data to identify baseline measurements for clinical indicators associated with high-prevalence chronic conditions and overall health status. Quality performance improvement initiatives will be developed for low-performing indicators as appropriate, as AmeriHealth Caritas Iowa's affiliates have done across the country. We continuously improve and innovate our services based upon data and feedback to ensure members are receiving optimal care and outcomes.

Use of program data

AmeriHealth Caritas Iowa will identify key measures and results for ongoing monitoring from various internal and external sources. Performance goals and benchmarks, where available, are identified for each measure based on performance targets, industry trends, state experience and quality committee recommendations. Using SAS-based and other analytical tools, AmeriHealth Caritas Iowa's Medical Economics team will perform a more detailed drilldown analysis to understand the drivers of different results.

AmeriHealth Caritas Iowa's robust data infrastructure – described below – allows us to collect, clean, analyze and incorporate data from a variety of sources into our program evaluation and refinement cycles.

- **HEDIS/CHIPRA results —** We use Inovalon's Quality Spectrum Insight software, an NCQA HEDIS-certified product to create a HEDIS/CHIPRA reporting repository that allows us to run monthly reports on progress toward HEDIS goals, identify low performing measures, and drill down to the member and provider level. This dataset serves as the backbone for our care gap infrastructure, allowing us to provide alerts and reports on overdue or missing recommended services to providers and AmeriHealth

Caritas Iowa staff working with members. Provider-level data from this system also feeds our provider performance programs.

- **CAHPS results (adult and child versions) —** We partner with NCQA-certified vendors to collect and analyze member satisfaction using the CAHPS survey tools. Results are analyzed at the individual question level and at the composite score levels. Annually, we add approved questions to the survey to collect data on special areas of focus.
- **Participant experience survey (PES) —** AmeriHealth Caritas Iowa will partner with the State to conduct the participant experience survey for members receiving home and community based services (HCBS). The family version of the PES tool will be used for interviews with children and their families and for adults who are unable to participate independently.
- **Provider satisfaction survey results —** AmeriHealth Caritas Iowa will use an outside vendor to objectively collect and analyze data on practitioner and provider satisfaction with our utilization management, care management, quality, credentialing and provider service programs. The data collection tool is refined each year to collect data on areas of importance to the provider network.
- **Medical and pharmacy claim data —** Data from medical and pharmacy claim transactions are fed from our TriZetto Facets® claim/eligibility system to AmeriHealth Caritas' data warehouse. We will use data from AmeriHealth Caritas Iowa claim transactions, as well as historical claim data provided by DHS, as a starting point in our analyses of utilization rates, chronic care and maternity incidence and outcomes, clinical guideline performance and gaps and health outcome measurement.
- **Care management assessment data —** Data collected through the care management process is stored in our ZeOmega Jiva® care management system. Specific elements, including new member assessment responses, comprehensive and condition-focused assessments and barrier identification will be used to identify non-claim related areas of focus and member response to interventions.
- **Eligibility and Demographic Data —** Eligibility feeds and updated demographic information collected by the Member Service team is entered into our Facets® claim/eligibility system. Member race, ethnicity, language and ZIP code/census block data will be used to identify important sub-populations and geographic pockets with specific needs. Information on Medicaid category and length of enrollment with AmeriHealth Caritas Iowa is used to augment clinical risk score analysis.
- **Member disenrollment surveys —** The reason for disenrollment, along with specific question response for members who disenroll voluntarily, will be collected by the Service Operations department. Information from member disenrollment surveys will be used to identify potential areas of dissatisfaction and/or gaps in plan services.
- **Utilization data —** Utilization data will be collected through our clinical care management system Jiva® and through analysis of claim information. Data on requested and incurred services is used as the basis for analysis of utilization management processes, such as prior authorization, as well as in evaluating health outcomes and clinical guideline adherence.
- **Provider access and availability data —** We use GeoAccess reporting tools and data collected from provider assessments to evaluate network adequacy and provider adherence to appointment and availability standards.
- **Internal service data —** AmeriHealth Caritas' systems and processes are set up to enable collection of performance data for all key service areas. Data related to AmeriHealth Caritas Iowa service levels, including phone performance (speed of answer, abandonment rate, hold time); transaction time

(authorization and claim timeliness); and performance quality (claim accuracy, encounter acceptance, denial processing) are used to identify areas of weakness and opportunities to improve performance.

- **Delegate subcontractor reports —** Monthly subcontractor report data will be reviewed by staff overseeing delegate performance and aggregated to identify trends and potential areas for service improvement. Key areas of focus, as appropriate to the subcontractor's scope of service, include phone performance (speed of answer, abandonment rate, hold time), transaction time (authorization and claim timeliness), and performance quality (claim accuracy, encounter acceptance, denial processing, trip timeliness).
- **Clinical Risk Groups:** AmeriHealth Caritas Iowa will license Clinical Risk Groups (CRGs) algorithms from 3M. CRGs are a risk-adjustment tool and clinically-based classification system used to measure a population's burden of illness through longitudinal analysis of medical and pharmacy claim data. Each individual is assigned to a single, mutually exclusive risk group. CRGs use the historical, clinical and demographic characteristics of the member to predict the amount and type of healthcare resources that the member will use in the future.
- **Potentially preventable events:** AmeriHealth Caritas Iowa will also license algorithms and software to identify and measure potentially preventable events (PPEs) from 3M. PPE analysis is used to allow AmeriHealth Caritas Iowa the ability to target interventions to members whose utilization patterns are most likely to be positively impacted through improved access and coordination of healthcare services. Conversely, a reduction in the level and number of PPEs indicates more appropriate utilization of healthcare services and a member's ability to better manage his/her condition.
- **Member medical records:** AmeriHealth Caritas Iowa will collect data directly from member medical records to support analysis of health outcomes.

We incorporate internal performance targets, standards and external benchmarks into our internal key indicator monitoring and reporting as we work with the State and provider partners to identify areas for additional analysis and, as necessary, implement quality improvement activities and corrective actions.

Data Source and Findings	Action Taken	Health Plan
Pharmacy claim data: low medication adherence rates (proportion of days covered [PDC]) for oral hypoglycemic, anti-hypertensive and cholesterol-lowering (statin) medication.	Implemented 90-day refill program, allowing member to receive a 90-day supply of the targeted medication classes. Members incurred a single copay (where copay applied) and pharmacies were paid two dispensing fees as an incentive (the health plan saved by reimbursing two dispensing fees versus what would have been three 30-day supply fees).	AmeriHealth Caritas Louisiana AmeriHealth Caritas Pennsylvania Select Health of South Carolina Florida True Health Keystone First
Inpatient utilization data and member medical records: length of stay in the neonatal intensive care unit (NICU) was extended for members in need of ongoing apnea monitoring; network durable medical equipment (DME) providers not willing to provide the equipment.	Identified new network provider for home apnea monitoring services; changed payment policy to provide enhanced reimbursement for the service; engaged services of NICU consultant to participate in case discussions with health plan staff and educate treating providers, as needed.	AmeriHealth Caritas Louisiana

Data Source and Findings	Action Taken	Health Plan
Utilization data and claim data: sharp increase in claims for speech therapy services after removal of prior authorization requirement.	Reviewed records associated with submitted claims and re-instituted requirement for prior authorization for speech therapy services.	Select Health of South Carolina
Utilization data: frequent requests for out-of-network service agreements for medically necessary skilled nursing facility services and cochlear implants.	Added to health plan network through change in payment policy to provide enhanced reimbursement for the service to qualified providers.	AmeriHealth Caritas Louisiana
Interim HEDIS results for health outcome measures: Significant volume of members missing or overdue for recommended services.	Implemented provider bonus campaign to incent providers to arrange for members in need of recommended services to receive the clinically recommended care.	AmeriHealth Caritas Louisiana AmeriHealth Caritas Pennsylvania AmeriHealth Caritas District of Columbia Keystone First Arbor Health Plan

Exhibit 10.1-I: Example Findings and Quality Improvement Actions across AmeriHealth Caritas

Race, ethnicity and language data collection

Each plan routinely analyzes health outcomes for race, ethnicity and language (REL) sub-populations. Through this analysis, we identified that both member and provider REL data in our systems was insufficient. Most of our data used the Office of Budget Management (OMB) classifications for race and ethnicity, which do not adequately address many populations. For example, using the OMB classification, a recent immigrant from Jordan is in the same “Asian” category as a second-generation Chinese-American. Accurate REL data is necessary to understand the composition of the membership and network and helps to identify actionable healthcare disparities.

To improve this deficiency, AmeriHealth Caritas invested in system enhancements and changes to staff protocols to allow for independent and specific REL data capture, storage and retrieval. Since a high percentage of members’ REL data found on the States’ enrollment files are incomplete and or inaccurate, it was determined that a mechanism was needed to obtain REL data directly from the member and provider.

During the new plan orientation call, and at other touch points with the Member Service and Care Management team, members are directly asked about what languages they prefer to use in medical contexts (for reading and speaking), as well as their race and ethnicity. Data obtained directly from the member is added to our information systems so that it is accessible for ongoing communication with the member, as well as reporting. While the updated information takes precedence in our future contacts with the member, we do not overwrite the data received from the state.

Annually, providers are surveyed for their own REL data to determine the network’s cultural responsiveness as culturally competency is a necessary component of a high-quality healthcare system. Provider network language capacity is analyzed against our membership in each area annually, in order to ensure we are meeting the language needs of our members. In areas with opportunities, the Provider Network Management team puts a plan in place to address any gaps or identified needs.

Reduction in racial and ethnic healthcare disparities to improve health status

AmeriHealth Caritas' goal is to deliver care that respects the uniqueness of each member and directly benefits the communities we serve. Each AmeriHealth Caritas health plan has a distinct composition of REL. Review of the REL data for each plan confirmed that within our diverse population, many members in linguistic, racial and ethnic minority groups continue to have poorer health and lower-quality healthcare.

Member and provider feedback

AmeriHealth Caritas Iowa will use a variety of mechanisms to understand and incorporate member and provider feedback into our operations. We capture and trend member and provider dissatisfaction and grievances, to alert us to operational areas that need improvement. Our Stakeholder Advisory Council provides input, feedback and recommendations into many of our program areas. We also use member focus groups, as needed, to help us understand how best to design our programs. Finally, we do formal member and provider satisfaction surveys to evaluate key program areas.

Member satisfaction surveys

AmeriHealth Caritas will conduct a member satisfaction survey using the CAHPS® and the Iowa PES tool annually. CAHPS is designed to collect information on consumers' experiences with health plans. The PES is used for members receiving home and community based services (HCBS). The family version of the PES tool will be used for interviews with children and their families and for adults who are unable to participate independently. Results of the surveys will be analyzed and compared against available benchmarks, our health plan goals and other health plan results.

For findings that do not meet organizational goals, an analysis will be completed so that potential barriers can be addressed. This thorough analysis will include additional data to assist in the identification of improvement opportunities. Information, such as member complaint/grievance data and member disenrollment data, are included in the analysis. This information provides more details around the CAHPS results and supports identification of geographic drivers. Identified opportunities are prioritized based on several factors, including relevance to the membership, barriers, likelihood to affect change and ability to implement.

Survey results and resulting analysis are shared with the Partnership Council for input on plans. The results and final plans are reviewed by the QAPIC for additional discussion, evaluation and approval. Results of member satisfaction surveys and any resulting plans or initiatives are communicated to members and providers through the quarterly newsletters.

Member focus groups and targeted surveys

In addition to a formal annual CAHPS-driven member satisfaction survey, AmeriHealth Caritas Iowa will systematically monitor members' patterns of accessing healthcare with a variety of qualitative surveys and focus groups for all of our programs. For example, seven AmeriHealth Caritas plans ran postpartum focus groups in the first quarter of 2015 to improve our understanding of member perceptions and behavior drivers for postpartum visits, and field-test some of the messaging we use to communicate about perinatal health activities. Data analsysis is still underway, however early learnings indicate many members believe they had a postpartum visit, despite the absence of a claim or physician visit note during the postpartum visit window.

Analysis of dissatisfactions and grievances

AmeriHealth Caritas Iowa will analyze data on dissatisfactions and grievances captured through provider and member call tracking and the grievance system. Data is analyzed looking at a combination of broad and specific topics, enabling us to zero in on specific drivers. As an example, tracking information related to calls expressing dissatisfaction with service from a provider captures the name of the provider, the nature of the service and the nature of the dissatisfaction or grievance. For a call related to an AmeriHealth Caritas process, such as not receiving an ID card timely, we can identify the grievance as a health plan issue related to ID cards and related to timeliness. This allows us to trend issues related to a specific provider, plan process or service and aggregate the data in a meaningful way.

Member Feedback Examples

Source	Feedback/Discussion	Action Taken
Feedback from Member Advisory Group (AmeriHealth Caritas Pennsylvania) following a presentation to the group on dental issues.	Members of the group suggested that the plan compile a list of participating dentists that could be given to medical providers so that they can relay this information to the members needing dental service.	Lists of dentists for each geographic area created and distributed to PCPs by network account executives. The PCP can hand the list to members needing preventive or other dental care.
Feedback from Member Advisory Group break-out session on improving HEDIS measures related to diabetes A1C testing.	Provide mobile phlebotomy to collect labs in home with a gift card incentive. Provide mobile phlebotomy at community events with gift card incentive.	Contracts for home phlebotomy services expanded and used for members in need of HgbA1c measurement and nephropathy monitoring. Gift card incentive added for members completing the needed care.
Feedback from members on the “Living Well” program for members with heart failure.	Members indicated that the name was being confused with “living wills.”	The program was renamed/branded as “HeartFirst.”
Member focus group feedback on postpartum care visits and Bright Start offerings after the birth of the child.	Members identified that there was not enough information provided on breast feeding.	Additional member education material on breast feeding is in the development/state approval process and will be added to the program.
Feedback solicited from parents of pediatric members who missed behavioral health appointments after their hospitalization.	Members reported that they did not keep the appointments because they did not want to have their kids miss any more school time after being hospitalized.	A program was implemented that uses home health agencies to go to a member’s home and provide therapy in the home in the afternoon.
Feedback from Member Advisory Group on educational materials addressing anti-violence.	The group felt the topic was important and requested to have direct input on material development.	A sub-team was formed consisting of Member Advisory Committee members, health plan community education staff and health plan communication staff to develop additional content and formats.

Source	Feedback/Discussion	Action Taken
Feedback from members received through community events and other interactions.	Many members request that programs are delivered directly in their neighborhoods.	In the past eight months, requested educational programs were delivered in more than 50 locations throughout the health plan's service area, including local churches, FQHCs, YMCAs, Boys and Girls Clubs and other community locations.

Provider surveys

AmeriHealth Caritas will build partnerships with network providers by monitoring their satisfaction, especially with administrative processes and our responsiveness to their inquiries. We will also assess provider satisfaction through regular surveys of practitioners and hospitals, inviting suggestions on how we can improve our services. Providers also offer feedback through the Partnership Council and other quality committees. Our QSC will gather this information and consider any patterns of provider complaints in making regular assessments of provider satisfaction and planning interventions and improvements.

Using an external vendor, AmeriHealth Caritas will perform a full provider satisfaction survey on an annual basis to assess provider satisfaction with our processes, staff and systems. Survey results will enable AmeriHealth Caritas to plan interventions and check the effectiveness of past strategies in improving provider satisfaction.

Provider service interactions

Provider Network Management representatives located throughout Iowa will make site visits to providers on a regular basis to ascertain provider satisfaction. These informal, collegial meetings help provide an opportunity to listen to the concerns of the provider and/or staff on a personalized basis. During these visits providers are encouraged to discuss issues they may not have voiced, which will allow follow-up and resolution any problem or situation.

Provider education is critical to ensuring satisfaction, and AmeriHealth Caritas Iowa will conduct personal training on a variety of topics, including health plan orientation, quarterly claims training and cultural competence for provider staff. Our provider newsletter, in hard-copy mailings and available on our website, will contain valuable information on provider concerns, including prior authorization procedures, the latest HEDIS statistics, provider incentive programs and other topics of interest.

Provider feedback examples

Source	Feedback/Discussion	Action Taken
Medical director visit to Geisinger Center for Autism to solicit input on medical genetic testing; additional meetings held between the medical director and a local autism advocacy group.	The policy did not address specific testing indications and required a specific level of counseling.	Clinical policy adjusted to add specific indications for genetic testing and required counseling appropriate to the individual.
Quality team (medical director, pharmacist, quality director) visit to leading suboxone practice to solicit information on best practices.	Need to restrict providers prescribing suboxone to those who meet quality practice criteria.	Added requirements for prescribing policies and adherence monitoring to criteria for providers to be able to prescribe suboxone.

Source	Feedback/Discussion	Action Taken
Request from network surgeons to add coverage for gastric sleeve surgery.	Bariatric surgeons recommend gastric sleeve surgery over gastric bypass based on short- and long-term complication rates; however, the procedure was not covered by the state Medicaid fee schedule.	Agreed that the health plan would cover the sleeve surgery procedure and permit the use of a miscellaneous code. Joined with a group of surgeons to petition the State Medicaid agency to add coverage for the procedure to the fee schedule, so that it would be available for other Medicaid recipients in that State.
Request from plan providers through network account executive interactions to revise care gap alert time frames.	Care gap alerts for breast cancer and cervical cancer screening were displayed annually for members even though the preventive care recommendations indicated the service could be received every two or three years, respectively.	The logic to trigger the care gap alert was changed to align with HEDIS specifications, looking for a mammogram every two years and a cervical cancer screen every three years. Providers were notified via a fax blast.
Feedback from providers collected during focused outreach on discharge follow up.	PCPs identified that it was difficult for them to provide timely appointments for members after discharge from the hospital as they often were not aware that the member was admitted.	An automated fax was developed that is sent to the PCP office.
Call from provider in response to denials for Crinone® gel (for high-risk pregnant women with shortened cervix).	The physician reported that some prior authorization requests that she deemed appropriate use of the medication had been denied. We pulled data on these requests and did find that some appropriate requests were being denied as requests for fertility (an excluded category) when, in fact, they were being requested for pregnant women with short cervix. In addition, there was a claim edit that was alerting with the message “fertility drugs are excluded.”	We re-educated prior authorization staff to be more attentive to the need and to differentiate between a request for a pregnant woman with a short cervix and one seeking to become pregnant. We removed the configuration for the claim error code. We revised our review criteria for the medication to specifically identify the appropriate use of the medication for at-risk populations.
Feedback from providers to the network account executive.	The plan added coverage for two albuterol (rescue) inhalers for school-age children when the second inhaler is requested by the physician. The providers felt the process was burdensome.	The plan revised the payment configuration to automatically permit payment for two inhalers for school-age members.

Source	Feedback/Discussion	Action Taken
Feedback from providers during a provider symposium meeting.	One provider mentioned that the office did not have anything to give a member to reinforce the importance of a postpartum physician visit.	The health plan's Bright Start and communication teams developed a brochure and made it available to providers.
Medical director outreach to leading infectious disease physicians at Drexel University (also member of the AASLD national guideline committee) and University of Pennsylvania to solicit input on clinical policy for hepatitis C management.	Draft policy did not acknowledge that in some populations up to one-third of people with hepatitis C are co-infected. Since HIV can make the person more susceptible to the hepatic damage of the hepatitis C virus, the guidelines on whom to treat needed an adjustment.	The guidelines were adjusted to recommend a lower threshold for treatment for people co-infected with HIV and hepatitis C than those with hepatitis C alone.

3. Detail your experience in and strategies for improving quality indicators, including HEDIS measures, CAHPS measures and satisfaction surveys. Describe how you will apply that experience in Iowa.

AmeriHealth Caritas understands how critically important ongoing measurement and evaluation are to the evolution of quality care delivery. Our rich heritage of performance for Medicaid populations is founded, in large part, on the development and implementation of quality measures and improvement processes — both grounded by our comprehensive data aggregation and analysis processes.

We will leverage the experience and best practices we have developed in other markets to create and implement successful initiatives to improve quality indicators (e.g., HEDIS, CAHPS, satisfaction) in Iowa.

Identifying performance improvement projects

AmeriHealth Caritas Iowa will actively seek opportunities to improve the quality of care and services we provide for our members and providers. As described above, we will monitor performance, analyze process and outcome data, compare our results to benchmarks and prioritize areas of focus for quality improvement plans. Highest priority is given to those areas that affect large segments of our population and evidence a strategic fit with our goals: improving efficiency, effectiveness and customer satisfaction.

As we frame the opportunity and begin to develop the plan, we ask ourselves three questions:

- What are we trying to accomplish?
- What changes can we make that will result in improvement?
- How will we know that the intervention resulted in an improvement?

We set "SMART" goals, ensuring that each is:

- **S**pecific.
- **M**easurable.
- **A**ttainable.
- **R**ealistic.
- **T**imely.

We understand that some projects will have a lifecycle where results are not available until late in the next measurement period. Projects using HEDIS measures as metrics are one example. In these situations, we attempt to identify interim measurement strategies to assist us in performing ongoing evaluation of our efforts. For annual incremental goals, we use a formula to identify expected annual achievement where the goal is equal to the lower of five percent or (1-x)/20 where "x" equals the baseline result.

Wherever possible, we use national benchmarks, such as the NCQA Medicaid HEDIS/CAHPS percentiles or State averages. When those metrics are not available, we use our past experience, looking for year-over-year improvement.

Focused work teams

As part of the planning process, we form a workgroup consisting of representation from stakeholders and subject matter experts. The workgroup conducts additional analysis using techniques appropriate to the identified opportunity. For example, to understand the cause of member dissatisfactions related to the primary care office, the group analyzed data and collected information to outline the drivers. A similar approach was used by AmeriHealth Caritas' southeastern Pennsylvania plan, Keystone First, to outline the drivers behind low performance on early prenatal care metrics as illustrated in the graphic below.

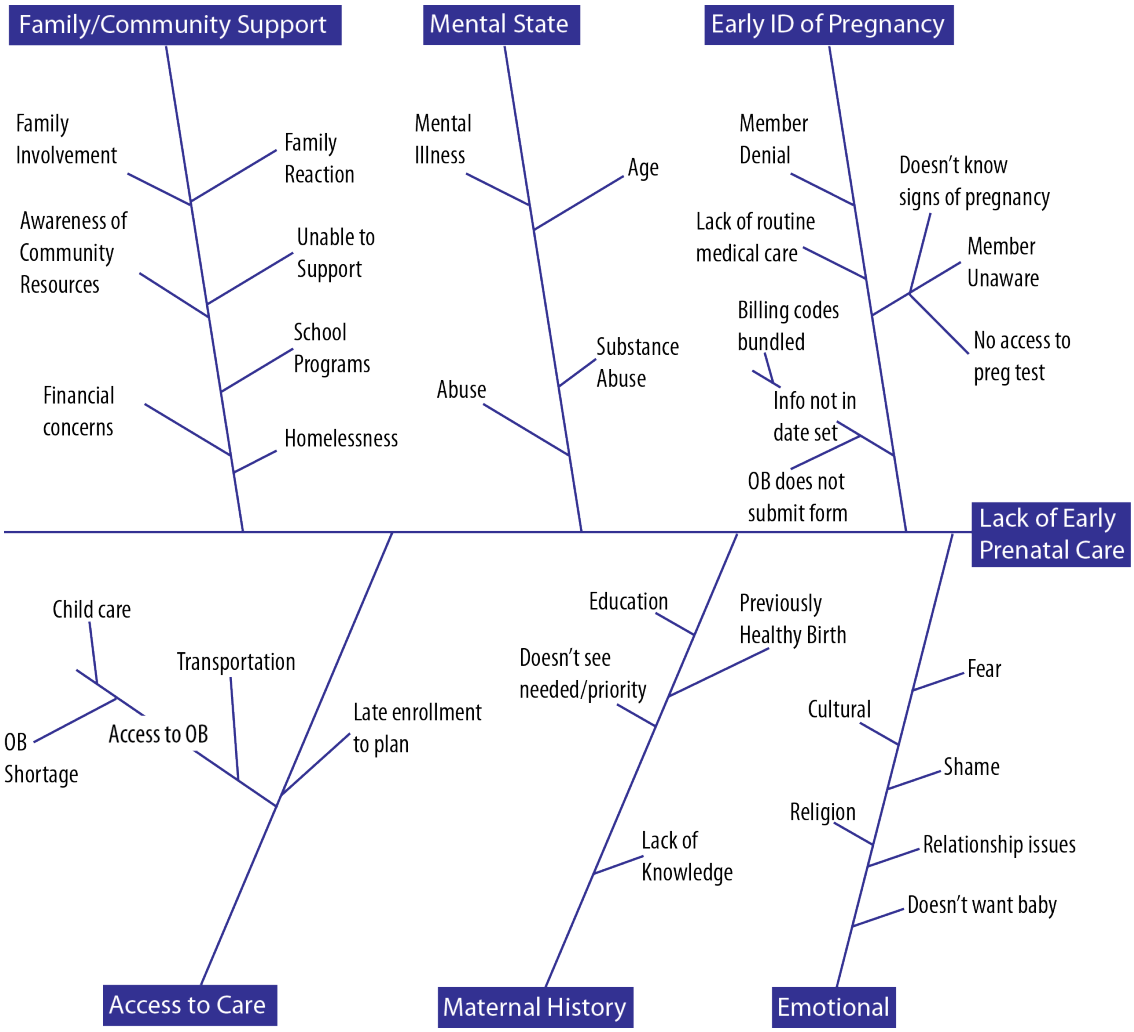


Exhibit 10.1-J: Drivers Behind Low Performance on Early Prenatal Care Metrics

To better understand and to plan interventions to address women's preventive health measures, Keystone First conducted focus groups with women who were compliant with screening recommendations and those who were overdue or had no record of screening. We added supplemental questions to the CAHPS tool to understand the reasons members had difficulty accessing care from a specialist. When addressing high ER utilization, we identified otitis media as a high volume/low acuity ER diagnosis, and analyzed the member ZIP codes from the claims to use in our urgent care center contracting efforts.

Interventions are designed by the work group based on understanding of the drivers, review of industry best practices and consideration of input from stakeholders and subject matter experts. Intervention costs are weighed against the benefit and supplemental funding sources are considered. For example, when Pennsylvania introduced funding for Medicaid pay-for-performance, we were able to use some of the money we anticipated we would earn to reimburse PCPs above the capitation rate for performing a cervical cancer screening (PAP test) in their office, one of the incented pay-for-performance measures. Other interventions include contracting with a vendor to provide network physicians with finger-stick lead screening test kits and implementing a point-of-service incentive program for members receiving screening mammograms.

Evaluation

Where possible, we use the same methodology to evaluate the program as was used for the baseline measurement. Occasionally we need to revise our metrics if we are using national specifications, such as HEDIS or CAHPS, and changes were made to subsequent year measure specifications.

The results of re-measurements are compared to the cycle goal and the identified benchmark. In addition to looking at trends, we measure for statistical significance using a t-test or other appropriate statistical vehicle. The analysis includes identification of barriers that impacted the interventions. Where possible, strategies are designed to address identified barriers in the next measurement cycle.

Quality projects are terminated when project goals are met, new technology or guidelines diminish the value of the project, measure specifications change to such an extent that no future comparison is possible, or the goals remain unmet and a decision is made to take a radically different approach.

The QAPIC reviews the prioritization, plans and results of quality improvement activities and projects. The workgroup lead presents the findings and recommendations to the QAPIC. The QAPIC approves and/or makes additional recommendations to the workgroup. Any decision to end or revise the approach to a quality project is reviewed and approved by the QAPIC.

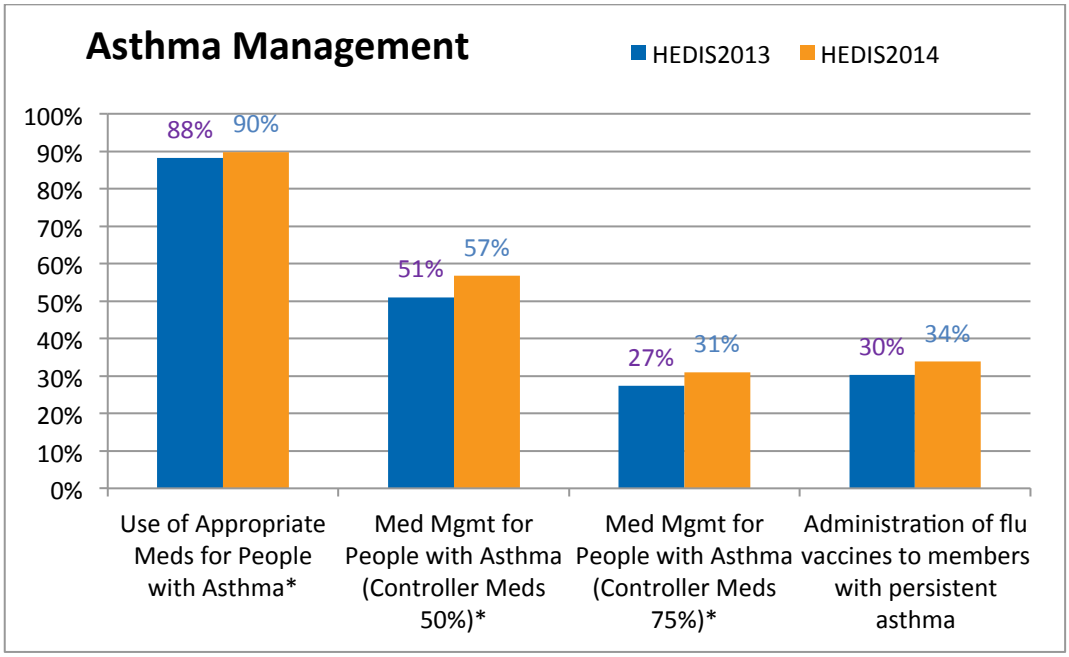
Track record of success

In addition to the several examples of improved quality indicators discussed throughout this section, two additional examples of focused quality improvement efforts from AmeriHealth Caritas Iowa affiliates are provided below.

Example #1 — Select Health of South Carolina

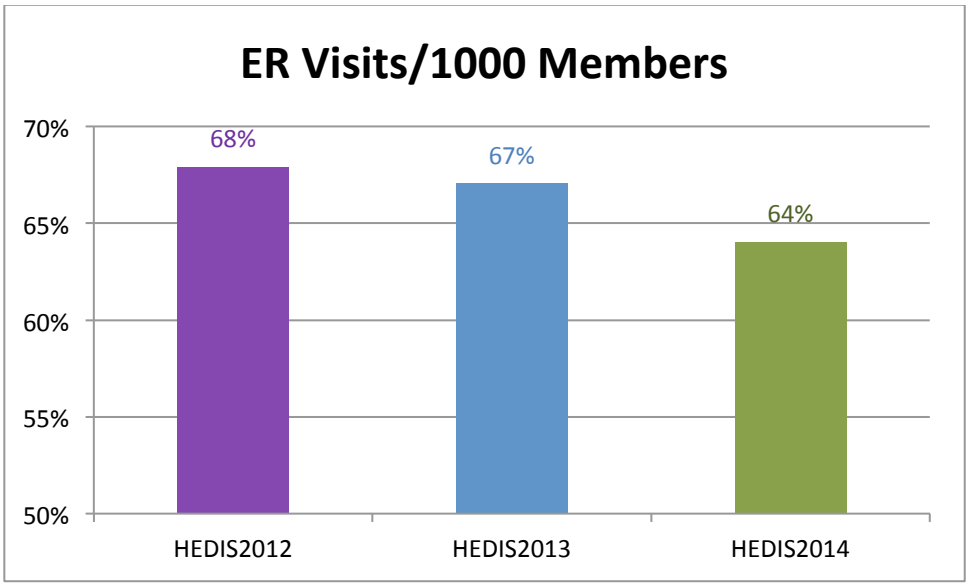
SHSC	Asthma Medication Management	Clinical
Goal	To improve asthma management in members with persistent asthma, including appropriate medication use (by 2 percent), medication management and administration of Influenza vaccines (by 5 percent each).	
Time frame	Baseline January 1, 2012 to December 31, 2012	M1 January 1, 2013 to December 31, 2013

SHSC	Asthma Medication Management	Clinical
Identified Barriers	Member education regarding the importance of receiving an annual flu vaccine. Provider practice variation in adherence to recommended asthma guidelines. Member education regarding asthma, self-management and treatment of asthma. Education of asthma care to caregivers in school and/or community settings. Member age may be a factor for compliance with asthma controller medications.	
Key Interventions	October – November — auto message ("sound bite") to identified high-risk members reminding them to follow-up with their PCPs to obtain an annual flu vaccine. October – January — customer service reminders (CSRs) after completion of inbound and outbound calls. (Member service CSRs will provide education on the importance of receiving flu vaccines and encourage members to follow up with their PCPs to obtain vaccine.) Promotion of clinical alerts on Provider Portal — alerts provide health-related information to providers that can be used to improve adherence to care guidelines and prompt the provision of recommended clinical services to members. HEDIS Year-to-date incentive offered to providers who scheduled an office visit with a member that has asthma to discuss their healthcare needs. Release of Clinical Summary Reports through the Provider Portal — this summary report provides information on members for medications, chronic conditions, gaps in care, ER visits, inpatient admissions and office visits. Health fairs to distribute asthma education information; added two additional community events for children with asthma. A process was added to case management outreach efforts for those with medication non-compliance for referral to a community outreach team for home visits to those that could not be reached by phone. Coordination with Family Connections/Project Breathe Easy for referrals of members with suboptimal medication compliance. A specific outreach effort was made to members who self-identified as having Spanish as their primary language. Case management staff presented communication with local pharmacies as on ongoing barrier for this population. Members (or their responsible party) were educated on how to receive translator services, were advised of Spanish speaking providers in their area and were offered educational materials and information for a mail order pharmacy in Spanish. Members of the quality staff attended state and district school nurse events to provide asthma related educational materials for schools and to assess and address any barriers to students asthma care. The team was subsequently invited to two school-based events to further assist students in the community with asthma care. Targeted outreach to providers with members below the threshold for compliance with appropriate controller medication. The members were identified via pharmacy data for being at risk for lack of controller fills.	

SHSC	Asthma Medication Management	Clinical
Results		
Analysis	The 5 percent goal for appropriate medication management for members with persistent asthma was met for controller medication: 50 percent for all age groups (including combined) except for ages 51 – 64, and for all age groups (including combined) without exception for controller medication 75 percent. The goal of a 5 percent annual increase in administration of influenza vaccine was met. The appropriate use of asthma medications has had a statistically significant upward trend for all age groups except for the 19 – 50 year olds (4.21 percent increase) for the 2014 HEDIS year. Select Health falls above the 75 percent NCQA benchmark for all but the 19 – 50 year age group (above 50 percent). This progress for the majority of age groups may be attributable to increased outreach efforts to the new member population along with the established asthma population. The health plan recognizes an opportunity to institute new interventions specific to the 19 - 50 age group members to overcome barriers and access appropriate medications and care.	

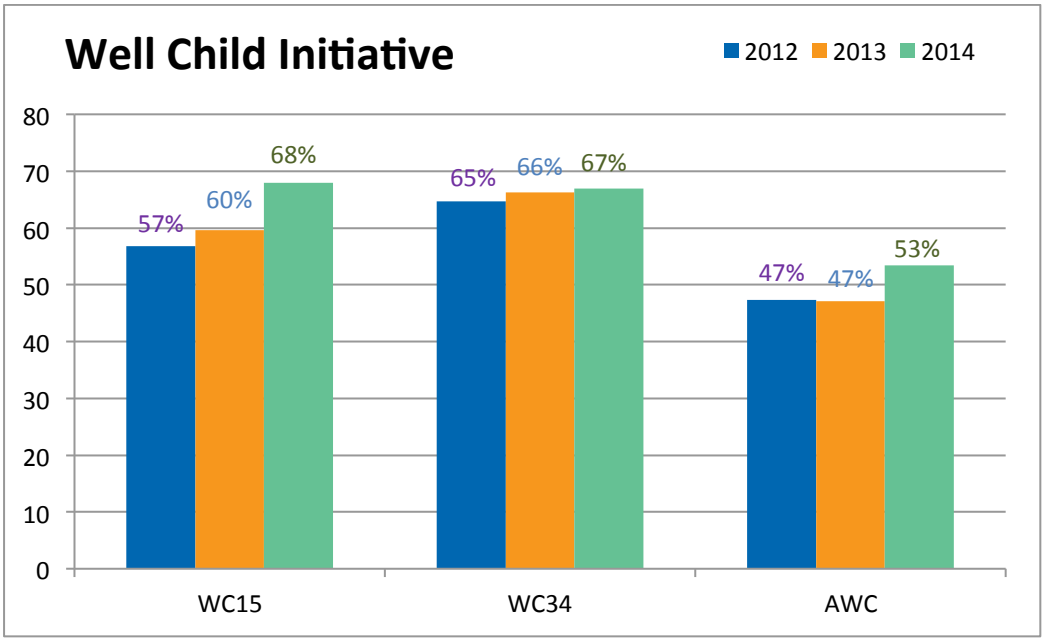
Example #2 — Keystone First

KF	Reducing Emergency Room Admissions		Clinical
Goal	To reduce the rate of emergency room (ER) utilization where other more effective and cost-efficient alternatives exist.		
Time frame	Baseline January 1, 2011 to December 31, 2011	M1 January 1, 2012 to December 31, 2012	M2 January 1, 2013 to December 31, 2013 2012
Identified Barriers	Members unaware of available ER alternatives. Parents of small children anxious when faced with a sick child. Unmet care needs related to underuse of primary care.		

KF	Reducing Emergency Room Admissions	Clinical
Key Interventions	During the measurement years, education was provided to providers and parents, including the following: 4 Your Kids Care program (facilitated over 100 classes in 2013, over 508 head of households attended; referred 67 children members to care management). Daily ER admission data from largest children's hospital (1,347 outreach calls made). Letters explaining the proper use of ER sent to members who utilize the ER for a potentially ambulatory diagnosis. Promoted availability of 24-hour Nurse Call Line through mailing of refrigerator magnets. Acute care transition nurse met with members in the ER (two facilities). Urgent care center listing posted on member and provider websites. Chester-based programs that include comprehensive health and social service for high-risk and high-ER utilizer members (30 members engaged in program). Community Outreach Solutions team outreach — in-person outreach to members who have not been seen by PCP to re-engage them in care and minimize ER use (1,538 total home visits made by COS team, 1,929 appointments made with 50 percent success rate).	
Results		
Analysis	Over the last two years, Keystone First experienced a steady decline in ER visits per 1,000 member months. The health plan's Provider Network Management department continues discussions with providers on issues of access to care for members and ER utilization. Furthermore, Keystone First utilizes the 4 Your Kids Care program as a member education tool to better educate members and parents of child members on the availability of the 24/7 Nurse Call Line, urgent care centers and proper ER utilization.	

Example #3 — MDwise Hoosier Alliance

MDHA	Well-Child Initiative		Clinical
Goal	To improve the rate of annual well-child visits to network providers by 5 percent over two years		
Time frame	Baseline January 1, 2012 to December 31, 2012	M1 January 1, 2013 to December 31, 2013	M2 January 1, 2014 to December 31, 2014

MDHA	Well-Child Initiative	Clinical
Identified Barriers	Member awareness of the importance of well-care visits. Members that were "no-shows" routinely scheduled appointments. Many provider offices lack adequate staff to make outbound well visit calls to their patients.	
Key Interventions	High-volume, low-performing provider groups were identified for assistance with member outreach. Health plan rapid response staff contacted members and used three-way calling to schedule appointments. "Everyone Needs a Check-up Day" events held at targeted provider offices with 200 or more non-complaint members. Well-child member reference cards were created to be used at outreach events to promote well-child visit schedules, immunization schedules and 24/7 nurse line. Members associated with small-provider offices (10 or less members) were sent a member incentive letter offering a gift card to complete the well-visit. Intensive medical record reviews were completed throughout 2014 to identify well-visits for members in the W15 measure completed in the first 30 days of life requirement. Intensive medical record reviews were completed throughout 2014 to identify well-care visits completed for members who may have other primary (TPL) insurance that paid for well-visit in full. Account executives coordinated block scheduling events "Healthy Hoosier Days" for smaller-provider offices (with less than 200 panel members) which offered a gift card to members who completed a well-visit on the event day. Members in the adolescent well-care denominator who may be entering high school were sent a reminder letter to have a state required immunization before October that encouraged a well visit at the same time.	
Results	 W15 - The percentage of members who turned 15 months old during the measurement year and who had a minimum of six well-child visits prior to turning 15 months. W34 and AWC - The percentage of members 3 – 6 and 12 - 21 years of age who had one or more well-child visits with a PCP during the measurement year.	

MDHA	Well-Child Initiative	Clinical
Analysis	Rates for WC15 improved by 5 percent each year, exceeding the goal. Rates for WC34had a statistically significant increase over the two years, but were one percentage point below the goal. Rates for AWC exceeded the goal of a 5 percent increase over two years.	

4. Describe your experience and strategies in working with network providers to improve outcomes.

We work collaboratively with network providers, aligning incentives and sharing information, to improve health outcomes for our members. Our approach incorporates an active Network Account Executive team, dedicated clinical educators, a robust portfolio of value-based contracting models (PerformPlus®), embedding staff in provider offices and facilities and actionable information sharing.

Network account executives

As described in Section 6, our state-wide Network Account Executive (AE) team is a critical component of our strategy to partner with providers to improve outcomes. AEs work directly with providers and their office staff to communicate quality goals, ensure provider access to performance data, gather feedback on provider barriers and leverage additional health plan resources to assist the provider to impact our members. AEs provide training to office staff on accessing member- and panel-level information for the practice, so that the provider knows which members are missing recommended services (such as a well-care visit) or have conditions that require monitoring, such as hgbA1c screening for members prescribed antipsychotic medications.

The AEs also keep providers' offices informed of planned quality activities and priorities for the health plan. For example, AEs alert the offices to bonus campaigns run during the year, which pay additional monies to the providers for targeted services, such as adolescent well-care visits. The AEs will also work with the providers to identify ways that AmeriHealth Caritas Iowa can assist the providers to meet quality outcome goals. For example, the AEs may organize outreach campaigns for the offices to have members in need of screenings or other services schedule an appointment.

Clinical educators

AmeriHealth Caritas Iowa's clinical educators will provide additional support and education to providers and office staff on key topics that drive important member outcomes. The initial focus for the AmeriHealth Caritas Iowa clinical educators will be on management of depression in the PCP office and cholesterol management. Additional planned topics include management of anxiety disorder and trauma-informed care principles. Clinical educators will schedule time convenient for the provider and the office staff.

Each topic presented will include a provider tool kit containing additional information, desk-top resources and additional assistance available from AmeriHealth Caritas Iowa. For example, the depression management tool kit includes information on PHQ9 and PHQ9a screening, first-line treatment regimens for depression, guidelines for evaluating treatment response and the mechanism to refer the member for additional therapy if the first-line treatment is not successful. The goal is to give the provider the tools necessary to successfully manage the member's needs.

Value-based programs

AmeriHealth Caritas Iowa recognizes that best practice occurs when goals are aligned between the State and the supplier. By incorporating the goals that are defined by the State's Value-based Program (VBP) into our contracting and incentive programs, AmeriHealth Caritas Iowa is able to present these goals to the provider and ultimately the member to make Iowa a healthier State.

AmeriHealth Caritas has over 30 years of managed care experience, and has learned that providers are more actionable when pay-for-performance drivers are in place to incent behaviors, and that value-based purchasing can be a catalyst for continual improvement. AmeriHealth Caritas Iowa will regularly monitor provider performance to ensure the tools and resources provided via the PerformPlus shared savings programs are leading to persistent improvements in quality of care.

AmeriHealth Caritas Iowa will use our data collection, analysis and reporting capabilities to drive improvements and cost effectiveness in our provider network. As best practices are identified, they will be shared with our providers. VBP trends will be used to guide investment decisions and program modifications. Provider performance will be used to steer members to higher-performing providers while eliminating the lowest performers from our provider network.

Regular trend analysis and annual assessments

Our Quality and Provider Network Management teams will regularly collect data about provider performance to identify trends indicating that quality of care may be at risk. This includes utilization patterns, HEDIS measures, claims submission/billing issues and even litigation activities against providers. As appropriate, corrective actions will be taken to rectify provider behaviors. These trends and activities will be considered during AmeriHealth Caritas Iowa's contracting and rate setting processes. Individual cases may also be peer reviewed by our Quality of Clinical Care Committee.

In addition to ongoing analysis, an annual provider performance assessment will be conducted to derive insights about the network. The assessments will help Quality staff identify providers who:

- Serve the largest number of members.
- Use the most effective condition management methods.
- Create best practices.
- Leverage patient centered medical home (PCMH) capabilities to best effect.

By identifying these providers, AmeriHealth Caritas Iowa will be able to better support them in innovating further. We will also work to circulate the innovations or best practices throughout the network so that our providers can deliver the best care possible to our Iowa members.

Provider report cards

One of the primary ways we will accomplish this is through provider report cards, which will be created for network providers, notably those participating in PerformPlus shared savings programs mentioned in section 10.3. The report cards will outline the provider practice's performance on specific quality indicators, including comparisons against previous years, as well as peers, and will be available via the Provider Portal at the end of a performance period. The goal of the report cards is to present meaningful feedback and identify causes and other contextual information so that providers have the intelligence they need to make changes within their practices/groups.

Provider network account executives will hand-deliver report cards and checks for any incentive payments the practice has earned at the end of the performance period. The account executive will sit down with

each provider to walk through the findings, including the practice's potential versus actual earnings. For providers who have demonstrated improvements, the chief medical officer will accompany the account executive on the provider visit. In addition to reviewing the report card results, the chief medical officer will have clinician-to-clinician discussions with the provider about the interventions used to achieve the change.

Embedded staff

We also partner with providers to embed care management staff at their locations. Each of these partnership arrangements is slightly different, depending on the needs and goals of the provider. Through these arrangements, we currently have care managers placed in hospital ERs and inpatient settings, primary care provider offices, community mental health centers and state behavioral health treatment sites. We are actively working on a partnership to place a Bright Start care manager in a high-volume maternity office providing care to many of our high-risk members in southeastern Pennsylvania.

We also embed our community care connectors in high-volume practices. The care connector meets with at-risk members identified by the practice while the member is in the office for the office visit. The care connector then follows up with the member at home to ensure that the member is able to successfully implement recommended treatment steps and medication regimens. The care connector will assist the member to access additional community and health plan resources to address identified barriers and treatment goals.

The care connector brings feedback on the member's progress and barriers identified during home visits back to the practice's clinical team. Weekly team meetings — called huddles — are led by the practice's clinical staff to review all of the high-risk members followed by the care connector. During the huddle, team members share information on their interactions with the member, review current information on the member's utilization and medication refills and strategize on next steps to assist the member to meet his/her goals.

The Keystone First, AmeriHealth Caritas Iowa's southeastern Pennsylvania affiliate, Community Case Management team has been instrumental in the management of the most medically and social-economically complicated patients of our practice. The opportunity to collaborate with nurses, social workers and community care workers from Keystone First, and more closely work with the patients themselves, allows us to better exchange information and combine resources. The results are expanded services and improved coordination of care for our challenging patients."

George Valko, M.D.
The Gustave and Valla Amsterdam Professor of Family and Community Medicine
and Vice Chair for Clinical Programs and Quality
Thomas Jefferson University Hospitals

Actionable information sharing

In addition to the dashboards and rich information sets available through the PerformPlus model described above, AmeriHealth Caritas Iowa will provide actionable information to providers at the point of care and as aggregate reports. When a provider office enters a member ID number into AmeriHealth Caritas Iowa's secure Provider Portal, the staff will see a pop-up alert if that member has a missing recommended service (gap in care).

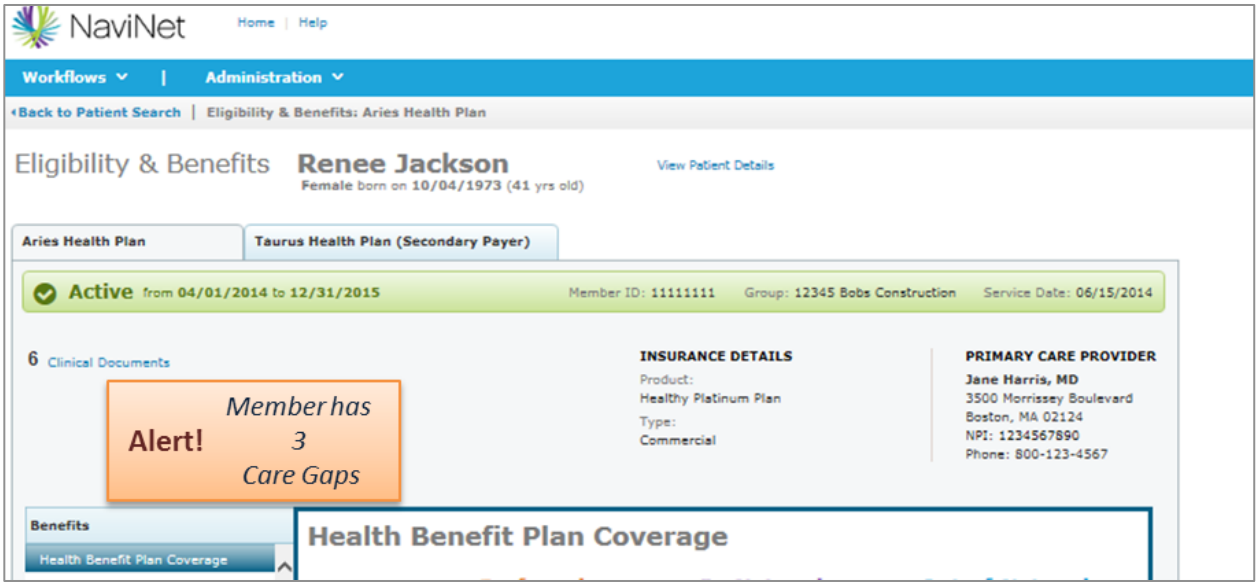
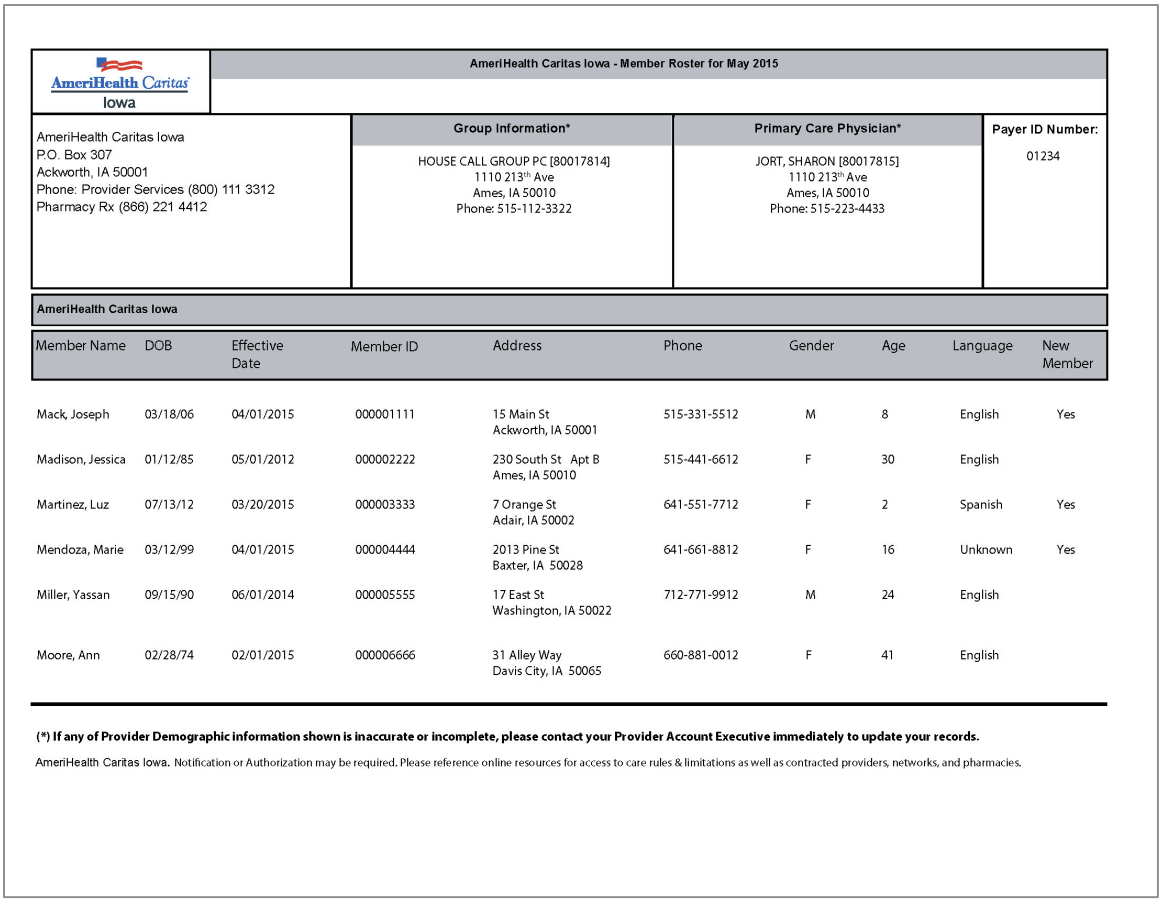


Exhibit 10.1-K: Care Gap Alerts Display on the Provider Portal

Clicking on the alert displays a member-specific care gap worksheet that identifies the missing or overdue service, along with a list of up-to-date care gaps for the provider's reference. The care gap worksheet is formatted to allow for easy printing and inclusion in the member's chart.

PCPs will be also able to access the information at the panel level, allowing them to use population management techniques within their practice. This panel-level information will be available as a printable report or a comma separated value (CSV) file for compatibility with other electronic systems.



AmeriHealth Caritas Iowa - Member Roster for May 2015

AmeriHealth Caritas Iowa P.O. Box 307 Ackworth, IA 50001 Phone: Provider Services (800) 111 3312 Pharmacy Rx (866) 221 4412	Group Information* HOUSE CALL GROUP PC [80017814] 1110 213th Ave Ames, IA 50010 Phone: 515-112-3322	Primary Care Physician* JORT, SHARON [80017815] 1110 213th Ave Ames, IA 50010 Phone: 515-223-4433	Payer ID Number: 01234

AmeriHealth Caritas Iowa

Member Name	DOB	Effective Date	Member ID	Address	Phone	Gender	Age	Language	New Member
Mack, Joseph	03/18/06	04/01/2015	000001111	15 Main St Ackworth, IA 50001	515-331-5512	M	8	English	Yes
Madison, Jessica	01/12/85	05/01/2012	000002222	230 South St Apt B Ames, IA 50010	515-441-6612	F	30	English	
Martinez, Luz	07/13/12	03/20/2015	000003333	7 Orange St Adair, IA 50002	641-551-7712	F	2	Spanish	Yes
Mendoza, Marie	03/12/99	04/01/2015	000004444	2013 Pine St Baxter, IA 50028	641-661-8812	F	16	Unknown	Yes
Miller, Yassan	09/15/90	06/01/2014	000005555	17 East St Washington, IA 50022	712-771-9912	M	24	English	
Moore, Ann	02/28/74	02/01/2015	000006666	31 Alley Way Davis City, IA 50065	660-881-0012	F	41	English	

(*) If any of Provider Demographic information shown is inaccurate or incomplete, please contact your Provider Account Executive immediately to update your records.

AmeriHealth Caritas Iowa. Notification or Authorization may be required. Please reference online resources for access to care rules & limitations as well as contracted providers, networks, and pharmacies.

Exhibit 10.1-L: Provider Panel Report

5. Outline the proposed composition of your Quality Management and Improvement Committee, and demonstrate how the composition is interdisciplinary and appropriately represented to support the goals and objectives of the Quality Management and Improvement Committee.

The Quality Assessment Performance Improvement Committee (QAPIC) oversees AmeriHealth Caritas Iowa's efforts to measure, manage and improve quality of care and services delivered to AmeriHealth Caritas Iowa's members as well as evaluate the effectiveness of the QAPI program. The QAPIC directs and reviews AmeriHealth Caritas Iowa's quality improvement and utilization management activities. The QAPIC reports through AmeriHealth Caritas Iowa's market president to the regional president and, ultimately, to the AmeriHealth Caritas Iowa board of directors.

The composition of the QAPIC, detailed below, includes representatives from the AmeriHealth Caritas Iowa network. Five subcommittees report in to the QAPIC: Quality of Service (QSC), Quality of Clinical Care (QCC), Culturally and Linguistically Appropriate Services (CLAS), Credentialing and Pharmacy and Therapeutics (P & T).

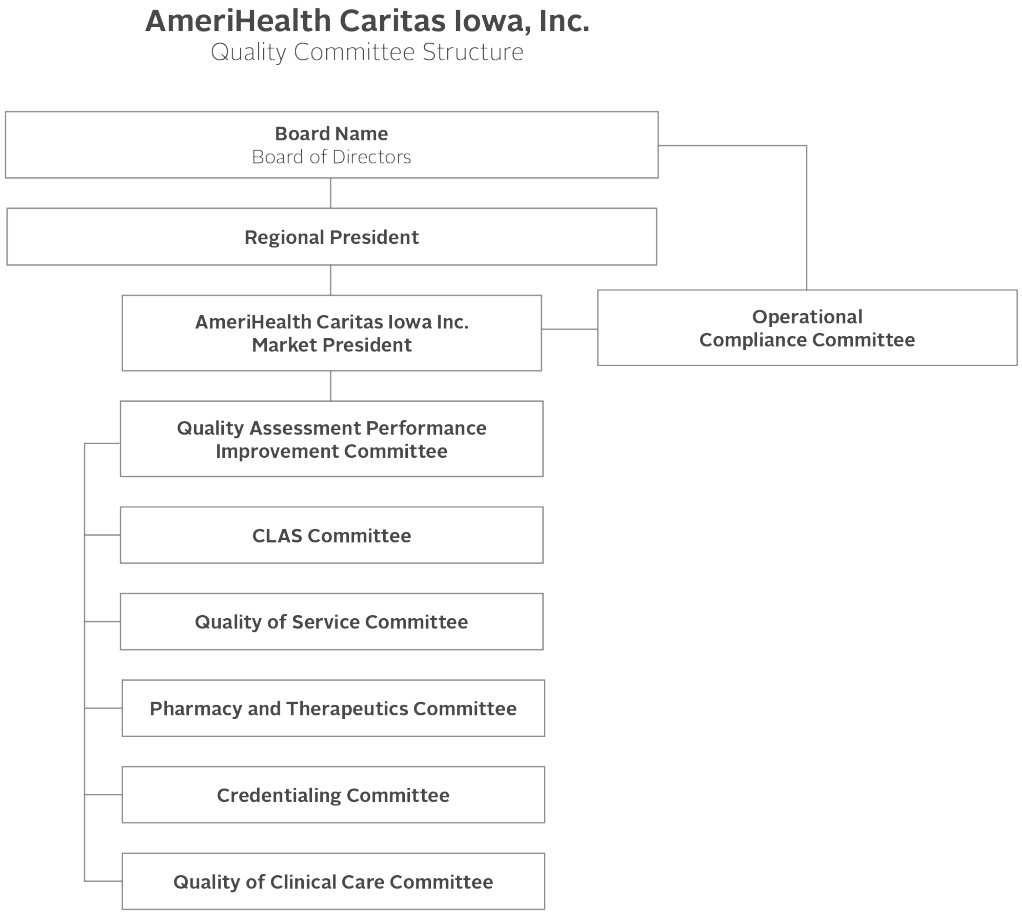


Exhibit 10.1-M: AmeriHealth Caritas Iowa Quality Committee Structure

QAPI Committee membership

The QAPIC will comprise a combination of AmeriHealth Caritas Iowa leadership and participating providers in the AmeriHealth Caritas Iowa network. The chairperson of the QAPIC is the AmeriHealth Caritas Iowa medical director. Additional AmeriHealth Caritas Iowa committee members include:

- Director of Quality Management.
- Director of Utilization Management.
- Director of Integrated Healthcare Management.
- Manager of Long Term Services and Supports.
- Director of Rapid Response and Outreach.
- Director of Provider Network Management.
- Director of Service Operations.

In addition, the QAPIC has voting members from the AmeriHealth Caritas Iowa provider network. The AmeriHealth Caritas Iowa medical director and Provider Network Management team will recruit interested providers to participate as committee members. Every effort will be made to recruit the following provider types:

- Two to three primary care providers, ideally including representation from a federally qualified health center (FQHC) or FQHC-like practice and a smaller practice.
- Two to three specialty physician providers, ideally including an OB/GYN.
- Two LTSS providers, ideally including an in-home service provider.
- One to two ancillary providers, ideally including a therapist.

By including the above mix of providers and health plan representatives, AmeriHealth Caritas Iowa will create representation to support the quality goals and activities important for the AmeriHealth Caritas Iowa member population. To encourage external provider participation, AmeriHealth Caritas Iowa will offer providers a stipend for meeting participation, provide light refreshments and schedule meetings at a time convenient to the external providers. For example, in our Pennsylvania-affiliate health plans, the QAPIC meets at 6:00 p.m., to meet the needs of providers participating on that committee; in our South Carolina- affiliate, the QAPIC meeting occurs at 7:30 a.m. We have begun conversations with providers in Iowa to introduce ourselves and our programs.

Stakeholder Advisory Council

The primary goals of the Stakeholder Advisory Council will be to improve the health status of members and to enhance service delivery to providers and members. The council will provide input and feedback to the QAPIC. Information gathered from the council will provide AmeriHealth Caritas with direction, feedback and the necessary support for our member outreach and quality improvement initiatives. We will use this forum to promote the medical home, develop policies and procedures, share best practices, establish priorities, evaluate findings and implement action plans as needed.

As described in Section 8.12 of our response, Stakeholder Advisory Council members will range in experience and will incorporate members (consumers), agencies (service providers) and advocates representing healthcare, the community-at-large and social issues impacting health equity. Insight and feedback from the Stakeholder Advisory Council will be used to make enhancements to programs and processes that may lead to improved customer service (members and providers) and health outcomes. We are committed to developing a robust membership roster for our Stakeholder Advisory Council. The following is a representative list of organizations we plan to recruit from:

- Central Iowa Shelter and Services.
- Child & Family Policy Center.
- Coalition for Family and Children's Services.
- Disability Rights of Iowa.
- Iowa Community Action Association.
- Iowa Health Care Association/Iowa Center for Assisted Living.
- Iowa Public Health Association.
- Leading Age Iowa.
- Lutheran Services in Iowa.
- Mainstream Living.
- The Arc of Story County.

Additional information on the Stakeholder Advisory Council can be found in Section 8.12.

10.2 State Quality Initiatives

1. Describe how you propose to work with the Healthiest State Initiative.

As discussed in Section 8.7, AmeriHealth Caritas Iowa applauds the Healthiest State Initiative, which supports addressing the "health of the whole person," and looks forward to partnering with DHS to promote this initiative as we move toward delivering the next-generation of healthcare in Iowa and help Iowa reach the #1 spot in the Gallup-Healthways Well-Being Index®. When selected, AmeriHealth Caritas Iowa will meet with DHS as soon as possible to identify and launch activities to support and achieve the goals of Iowa's Healthiest State Initiative. We share your belief that health is a state of complete physical, mental and social well-being and not merely the absence of disease or illness. We also believe that Medicaid beneficiaries should be provided the same tools available to all Iowans to help them learn how to make lifestyle changes to improve their health status. In addition to the programs previously provided that will support Iowa's health and wellness goals, AmeriHealth Caritas Iowa is ready to help promote Iowa's Healthiest State Initiative directly with members as well.

AmeriHealth Caritas Iowa's will offer a broad selection of community education programs and educational mobile applications that support Healthiest State program goals. These programs are open to all members of the community, and delivered in partnership with community agencies and faith-based organizations.

Several topics we plan to offer to support Iowa's Healthiest State Initiative:

- Before, During and After: Steps to a Healthy Pregnancy.
- Healthy You Healthy Me (childhood weight management, smart snacking and activity levels).
- Heart Health (separate curricula address children and adults).
- Many Tips for Healthy Living (health and wellness for men, including tobacco cessation).
- Outdoor Safety (summer safety tips for children).
- Stay Strong, Live Healthy (health and wellness for women, including tobacco cessation).
- Taking Care of Yourself, Healthy Tips for Teens (Health and wellness for teenagers, including tobacco cessation).
- Youth Sports Safety (reducing risks for sports-related injury for children ages 6 to 14).

AmeriHealth Caritas affiliates have partnered with government agencies on similar initiatives in the past. As an example, our affiliate health plan in Washington, DC, developed the "I am healthy" campaign to promote healthy living to members and the general public.

Exhibit 10.2-A: "I am healthy" campaign example

2. Describe how you propose to work with the Mental Health and Disability Services Redesign.

The Mental Health and Disability Services Redesign is a remarkable accomplishment for the state of Iowa in providing local services while also expanding choice for Iowans regionally and supporting better, integrated care. AmeriHealth Caritas Iowa is ready and able to support the state in making this transition.

The move to an MCO model including all populations and conditions is a natural next step in the Iowa Mental Health and Disability Services Redesign is supported by an integrated managed model of care. We focus on holistic care and empowering consumers to self-direct their recovery process, while keeping consumers in their communities and assisting them to live productive lives. AmeriHealth Caritas does not subcontract management of behavioral health services out to another company to manage and will directly and actively partner with Iowa and the Mental Health and Disability Redesign to meet its goals.

Integrated care support

- Facilitate behavioral health (BH)/physical health (PH) integration through our integrated model and medical record. We are a resource to the providers to see the bigger picture of their patient as we keep records of a member's pharmacy, PH and BH information. We can inform them regarding the other providers the member is seeing, what medications they are on and when they last got their prescriptions filled. We notify PCPs when one of their patients/our members has been treated in a mental health hospital setting to ensure that the PCP knows the aftercare plans and medications on discharge. Details on our information sharing capabilities and processes are outlined in Section 9.
- Hire clinical trainers to train PCPs about common behavioral health conditions, how to screen for them, first level treatment strategies and referral pathways for positive screens. We also ensure the PCP is paid for any behavioral health work they do.
- Address the stigma of mental health through the integration of services on the provider level. AmeriHealth Caritas' co-location models and telehealth offerings allow members to receive all of the services they need at the setting of their choice. For example, members who are comfortable receiving care at a local community mental health center should be able to receive physical healthcare in the same setting. We will work to have behavioral health service options available sites where members have connected with the PCP and are in need of behavioral healthcare.

Collaborate with current systems

- Collaborate with the regions to identify gaps specific to that region, then help design and implement a solution to fill the gap. Help the regions provide expanded core services and other innovative treatments.
- Work with the established integrated health homes to develop a model to specialize in care for the intellectually disabled (ID) population.

Supporting member choice

- Support the concept of keeping members in their communities and not in institutions/facilities (as discussed within Section 4 of this response). Our IHM model is based on empowering members to self-direct their treatment and self-manage their chronic conditions. We work with members to develop natural support resources and safety plans to enable them to be productive citizens and achieve recovery. We engage our members in planning and oversight of our programs. Our model involves supporting the member in developing their individualized plan of care; they choose who

participates in planning and intervening, they prioritize goals and they monitor progress with support from the health plan IHM.

- We will be flexible with providers of HCBS to allow them to provide the right amount of service at the right time. We will not dictate that services be provided a minimum of X hours per day; we will manage it at the aggregate level by applying some upper limits based on medical necessity (i.e., X hours per month) and allow the consumer and provider to determine the best times and ways to use those hours. If they need additional hours, the provider can request them with a medical necessity justification. Also, establish expected outcomes for providers and monitor for them. Hold providers accountable for providing quality care.
- Partnering with vendors to empower consumers to hire their own HCBS workers. Available platforms we are researching allow the members to create a profile of their needs and wants. The platform matches the member with available workers who meet those needs. The member is able to consider several choices and determine the best fit.

3. Propose strategies to incorporate the Value Index Score (VIS) as a tool to drive system transformation, and other strategies to support the State Innovation Model (SIM).

Value Index Score (VIS)

AmeriHealth Caritas has partnered with 3M since 2008 and has scaled the platform of preventable services and clinical risk grouping software to all states in which we operate. Components of the Value Index Score (VIS) have already been incorporated into our PerformPlus value-based programs and have proven successful in our historical and current partnerships. Specific VIS domains currently in use include:

- **Primary and secondary prevention measures —** included in our Quality Enhancement Program (QEP) PCP shared savings program and women's health program.
- **Tertiary prevention —** included in our PerformPlus shared savings program, QEP, cardiology program, oncology program and community partner's program for FQHCs.
- **Panel health status change —** currently provided via our Web Portal to all our PerformPlus shared savings program partners. We have been utilizing Clinical Risk Groupers (CRGs) in all markets for both clinical stratification and risk adjustment for several years.
- **Chronic and follow-up care —** a key component, potentially preventable readmissions (PPRs), is included in our PerformPlus shared savings program, cardiology, oncology and FQHC community partners program
- **Efficiency —** the relative efficiency of physicians is calculated by the total CRG risk-adjusted score in our QEP PCP model. Additionally, the total preventable services are a key component of both our internal clinical and external value-based strategy. Generic prescribing rates are provided, via our Web-based dashboards, on a monthly basis to all our value-based partners.
- **Continuity of care and patient experience —** tracked and reported in our quality initiatives and in several of our value-based initiatives via our patient attribution methodologies.

AmeriHealth Caritas is well positioned to adopt the 3M VIS, which uses the same metrics that are already part of our PerformPlus programs. We have implemented the full 3M platform in our affiliate health plans in Pennsylvania, South Carolina, Louisiana, Indiana, Nebraska and Washington, D.C., over the past seven years and are able to rapidly and accurately launch this as well as the accompanying value-based programs and transparency portals in Iowa.

State Innovation Model (SIM)

The goal of the State Innovation Model (SIM) grant is to transform Iowa's healthcare economy so that it is affordable and accessible for families, employers and the state and achieves higher quality and better outcomes for patients. Iowa is working to achieve this goal by implementing multi-payer Accountable Care Organizations (ACOs) and incorporating population health, health promotion and member incentives into the delivery system. Iowa received a model design grant in 2013 from the Centers for Medicare and Medicaid Services (CMS), and has applied for a testing grant to continue the work on transforming Iowa's healthcare delivery system.

In support of the Iowa State Innovation Model (SIM), AmeriHealth Caritas Iowa will leverage the enhanced payment models and information sharing capabilities of our PerformPlus portfolio. We will actively participate in the design of multi-payer arrangements, and contribute our expertise in payment modeling, risk adjustment and program design. The information we currently share through our PerformPlus dashboards can also be distributed through other channels, including a Health Information Exchange (HIE)-powered multi-payer information system.

4. Describe your experience in supporting a State authority in meeting the requirements of the Department of Health and Human Services Substance Abuse and Mental Health Services Administration Substance Abuse Prevention and Treatment Block Grant.

AmeriHealth Caritas currently supplies data to support New Jersey's state submissions for the substance abuse prevention treatment block grant through the Department of Health and Human Services (DHHS) Substance Abuse and Mental Health Services Administration (SAMHSA). Additionally, we supply data for the community mental health block grant to the New Jersey Division of Child Behavioral Health Services (DCBHS).

Our systems can be configured to collect and report a wide variety of data, depending on the reporting needs associated with the grant. We have a strong track record of on-time accurate delivery of reporting information. Additional information on our reporting capabilities can be found in Section 14.

5. Submit a project plan describing your specific approach and timetable for addressing this section.

Healthiest State Initiatives

Iowa's Healthiest State Initiatives are based on more than five key milestones intended to improve Iowa's 2014 score of #16 in United States to #1 by 2016. To support this effort, AmeriHealth Caritas Iowa will integrate key program components designed to increase the consumption of fruit and vegetables and to increase physical activity.

To spearhead this plan, AmeriHealth Caritas Iowa will identify a core team to focus on the key intersections between AmeriHealth Caritas Iowa's programs and Healthiest State goals. Success in this area hinges on communications. To address this we will leverage communications to our members via our community-based staff. We will also enhance provider communications to include key information on these initiatives. A detailed marketing campaign will be created.

Ensuring that information is distributed effectively, a feedback mechanism focused on participant surveys will be created. Information collected via these surveys will be collected, compiled and used to understand program penetration and identify ways to improve programs going forward.

Mental Health and Disability Service Redesign (MHDS)

In support of the Mental Health and Disability Service Redesign (MHDS), AmeriHealth Caritas will create an ongoing working team to review elements of the redesign and incorporate them in our approach. We will identify specific tasks to integrate MHDS In our QAPI work plan. The team will include representatives from different functional areas and external representatives from the behavioral health, LTSS and advocacy communities. Moving forward the team will create Year 1 strategies which will include the following: information sharing, LTSS/BH gap analysis, LTSS approver flexibility and primary care network training. A plan to address service gaps will also be created.

State Innovation Model (SIM)

Implementation of our support for the Iowa State Innovation Model (SIM) will be somewhat dependent upon the state's continued plans for that effort. We will actively pursue ACO-like agreements with willing providers in the state of Iowa and stand ready to assist with design elements and information sharing for multi-payer contracting efforts.

Value Index Scores (VIS)

To support the addition of the VIS capability to our existing array of Treo 3M modules, AmeriHealth Caritas Iowa will enhance our relationship with 3M to fully implement VIS calculation capability. We will educate internal staff on the use of VIS so that we can use the output in meaningful ways for our internal provider performance evaluation and as we assist providers to understand their performance in the context of the VIS output.

Substance abuse prevention and treatment block grant

To facilitate data in support of the substance abuse prevention and treatment block grant, AmeriHealth Caritas Iowa will map data submission requirements against currently available data, develop a data capture and reporting strategy for any missing data and test the output. If possible, we will send test files for validation, prior to submitting program data.

Project plan

A project plan that addresses the elements above, including a time table is outlined below.

Task Name	Duration	Start	Finish	Resource Names
IOWA RFP Section 10.2				
10.2.1 Healthiest State Initiatives (HSI)	**414 days**	**Mon 2/1/16**	**Thu 8/31/17**	
IDENTIFY TOPICS - Initiation				
Identify focused team to coordinate integration with HIS	3 days	Mon 2/1/16	Wed 2/3/16	Iowa/AmeriHealth Caritas teams

Task Name	Duration	Start	Finish	Resource Names
Identify and document key points from Iowa HIS	5 days	Thu 2/4/16	Wed 2/10/16	Iowa/AmeriHealth Caritas teams
Formulate plan to deploy and drive AmeriHealth Caritas initiatives in support of HIS	15 days	Thu 2/11/16	Wed 3/2/16	AmeriHealth Caritas deployment team
DEPLOYMENT APPROACH	**93 days**	**Thu 2/11/16**	**Mon 6/20/16**	
Focus on the consumption of produce	**35 days**	**Thu 3/3/16**	**Wed 4/20/16**	
Integrate promotion and use of produce coupons to members	15 days	Thu 3/3/16	Wed 3/23/16	Quality Director
Develop coupon distribution method(s)	20 days	Thu 3/24/16	Wed 4/20/16	Quality Director
Focus on Walking	**20 days**	**Thu 3/3/16**	**Wed 3/30/16**	
Identify and promote walking groups	20 days	Thu 3/3/16	Wed 3/30/16	Project Team, Quality Director
PLANNING	**93 days**	**Thu 2/11/16**	**Mon 6/20/16**	
Utilize community outreach teams	20 days	Tue 3/1/16	Mon 3/28/16	AmeriHealth Caritas deployment team
Collect information on partnership task	15 days	Tue 3/29/16	Mon 4/18/16	AmeriHealth Caritas deployment team
Review information for partners decision, plan leaders, market president, medical director	15 days	Tue 4/19/16	Mon 5/9/16	AmeriHealth Caritas deployment team
Integrate program availability with staff, care managers, Community Outreach, Care Management Teams	30 days	Tue 5/10/16	Mon 6/20/16	AmeriHealth Caritas deployment team
Develop marketing plan	90 days	Thu 2/11/16	Wed 6/15/16	Marketing Team
COMMUNICATIONS	**75 days**	**Thu 3/3/16**	**Wed 6/15/16**	
Provider Communications	**75 days**	**Thu 3/3/16**	**Wed 6/15/16**	
Create information	20 days	Thu 3/3/16	Wed 3/30/16	Communications Team
Complete internal review	5 days	Thu 3/31/16	Wed 4/6/16	Client facing team
State review of provider information	30 days	Thu 4/7/16	Wed 5/18/16	Iowa Team, Communications Team

Task Name	Duration	Start	Finish	Resource Names
Distribute information	20 days	Thu 5/19/16	Wed 6/15/16	Provider Communications
Internal Communications	**75 days**	**Thu 3/3/16**	**Wed 6/15/16**	
Create information	20 days	Thu 3/3/16	Wed 3/30/16	Communications Team
Complete internal review	5 days	Thu 3/31/16	Wed 4/6/16	Communications Team
Distribute information	20 days	Thu 5/19/16	Wed 6/15/16	Communications Team
REPORTING	**110 days**	**Thu 2/11/16**	**Wed 7/13/16**	
Establish reporting guidelines to measure increased population penetration	40 days	Thu 2/11/16	Wed 4/6/16	Project team
Develop workflow training to collect data	20 days	Thu 4/7/16	Wed 5/4/16	Trainers
Generate/review test reports	30 days	Thu 4/7/16	Wed 5/18/16	Quality Director
Launch reporting into production	30 days	Thu 5/19/16	Wed 6/29/16	IT
Confirm data meets defined requirements	10 days	Thu 6/30/16	Wed 7/13/16	Information Services
TRAINING	**120 days**	**Thu 2/11/16**	**Wed 7/27/16**	
Define training requirements	60 days	Thu 2/11/16	Wed 5/4/16	Training Manager
Create Training documentation	30 days	Thu 5/5/16	Wed 6/15/16	Training Material Staff
Deploy training internal staff and providers as necessary	30 days	Thu 6/16/16	Wed 7/27/16	Trainers
LAUNCH - AmeriHealth Caritas in compliance and supporting Iowa HIS	1 day	Mon 8/1/16	Mon 8/1/16	Project Team
FEEDBACK	**113 days**	**Thu 4/7/16**	**Mon 9/12/16**	
Develop plan to collect participant surveys	30 days	Thu 4/7/16	Wed 5/18/16	Quality Director
Begin collecting responses	20 days	Tue 8/2/16	Mon 8/29/16	Client facing team
Review responses	20 days	Mon 8/8/16	Fri 9/2/16	Quality Director
Create response report	3 days	Mon 9/5/16	Wed 9/7/16	IT, Quality Director
Distribute response reports	3 days	Thu 9/8/16	Mon 9/12/16	Quality Director
IOWA RFP Section 10.2				

Task Name	Duration	Start	Finish	Resource Names
10.2.2 2 Mental Health and Disability Service Redesign (MHDS)	**289 days**	**Tue 12/1/15**	**Fri 1/6/17**	
IDENTIFY TOPICS - Initiation	**15 days**	**Tue 12/1/15**	**Mon 12/21/15**	
Coordinate with Iowa team to understand all services associated with the Redesign	15 days	Tue 12/1/15	Mon 12/21/15	Iowa/AmeriHealth Caritas Teams
DEPLOYMENT APPROACH	**103 days**	**Tue 12/22/15**	**Thu 5/12/16**	
Map gaps between current AmeriHealth Caritas service offerings and redesign specified	20 days	Tue 12/22/15	Mon 1/18/16	AmeriHealth Caritas Deployment Team
Identify specific tasks to integrate MHDS to QA/QI plan representatives	15 days	Tue 1/19/16	Mon 2/8/16	Quality Director
Create sub team across function areas, BH provider community and LTSS	20 days	Tue 2/9/16	Mon 3/7/16	Quality Director
Create Year 1 Strategies	**48 days**	**Tue 3/8/16**	**Thu 5/12/16**	
Information Sharing	20 days	Tue 3/8/16	Mon 4/4/16	Information Services
LTSS/BH gap analysis	10 days	Tue 4/5/16	Mon 4/18/16	AmeriHealth Caritas Deployment Team
LTSS approver flexibility	10 days	Tue 4/19/16	Mon 5/2/16	AmeriHealth Caritas Deployment Team
Primary care network training	30 days	Fri 4/1/16	Thu 5/12/16	Trainers
Develop plan to address service gaps	30 days	Tue 3/8/16	Mon 4/18/16	AmeriHealth Caritas Deployment Team
COMMUNICATIONS	**65 days**	**Fri 1/1/16**	**Thu 3/31/16**	
Provider Communications	**65 days**	**Fri 1/1/16**	**Thu 3/31/16**	
Create information	10 days	Fri 1/1/16	Thu 1/14/16	Communications Team
Complete internal review	5 days	Fri 1/15/16	Thu 1/21/16	Quality Director
State review of provider information	30 days	Fri 1/22/16	Thu 3/3/16	Iowa Team, Quality Director
Distribute Information	20 days	Fri 3/4/16	Thu 3/31/16	Information Services
Internal Communications	**45 days**	**Fri 1/1/16**	**Thu 3/3/16**	

Task Name	Duration	Start	Finish	Resource Names
Create information	20 days	Fri 1/1/16	Thu 1/28/16	Communications Team
Complete internal review	5 days	Fri 1/29/16	Thu 2/4/16	Quality Director
Distribute information	20 days	Fri 2/5/16	Thu 3/3/16	Information Services
REPORTING	**90 days**	**Mon 2/1/16**	**Fri 6/3/16**	
Establish reporting guidelines	40 days	Mon 2/1/16	Fri 3/25/16	Quality Director
Generate/review test reports	20 days	Mon 3/28/16	Fri 4/22/16	Client-facing Team, Information Services
Launch reporting into production	10 days	Mon 4/25/16	Fri 5/6/16	Information Services
Based on reporting develop methodology to determine improvement	20 days	Mon 4/25/16	Fri 5/20/16	Quality Director
Forward report to QA/QI teams	10 days	Mon 5/23/16	Fri 6/3/16	Quality Director
TRAINING	**30 days**	**Mon 5/9/16**	**Fri 6/17/16**	
Define training requirements	30 days	Mon 2/1/16	Fri 3/11/16	Training Manager
Create training documentation	30 days	Mon 3/14/16	Fri 4/22/16	Trainers
Deploy training internal staff and providers as necessary	20 days	Mon 4/25/16	Fri 5/20/16	Trainers
Production date	1 day	Mon 6/20/16	Mon 6/20/16	Iowa/AmeriHealth Caritas Teams
FEEDBACK	**45 days**	**Wed 6/1/16**	**Tue 8/2/16**	
Develop plan to collect participant surveys	10 days	Wed 6/1/16	Tue 6/14/16	IS/Quality
Begin collecting responses	20 days	Wed 6/15/16	Tue 7/12/16	Information Services
Review responses	10 days	Wed 7/13/16	Tue 7/26/16	Quality Director
Create response report	3 days	Tue 7/26/16	Thu 7/28/16	Project team
Distribute response reports	3 days	Fri 7/29/16	Tue 8/2/16	IT
State Innovation Model (SIM)	**289 days**	**Tue 12/1/15**	**Fri 1/6/17**	
IDENTIFY TOPICS - Initiation	**20 days**	**Tue 12/1/15**	**Mon 12/28/15**	
Identify and review SIM requirements	20 days	Tue 12/1/15	Mon 12/28/15	AmeriHealth Caritas Deployment Team

Task Name	Duration	Start	Finish	Resource Names
DEPLOYMENT APPROACH	**140 days**	**Tue 12/29/15**	**Mon 7/11/16**	
Implement SIM to support medical homes and ACOs	30 days	Tue 12/29/15	Mon 2/8/16	Quality Director
Implement incentives to support healthy behaviors	30 days	Tue 12/29/15	Mon 2/8/16	Information Services
Identify targeted healthy behavior per grant	30 days	Tue 12/29/15	Mon 2/8/16	Quality Director
Map healthy behavior identify gaps	60 days	Tue 2/9/16	Mon 5/2/16	Quality Director
Deploy solution to address identified gaps	30 days	Tue 5/3/16	Mon 6/13/16	Information Services
Add healthy behaviors to CAREcard	20 days	Tue 5/3/16	Mon 5/30/16	Information Services
Gather current information on quality measures used for reporting	20 days	Tue 6/14/16	Mon 7/11/16	Information Services
Complete review and gap analysis	60 days	Tue 12/1/15	Mon 2/22/16	Quality Director
Implement build out of missing data per gap analysis	60 days	Tue 2/23/16	Mon 5/16/16	Information Services
Incorporate data into our provider network via Navinet Portal	60 days	Tue 5/17/16	Mon 8/8/16	Information Services
Develop and deploy contracting strategy with participating ACOs	120 days	Fri 1/1/16	Thu 6/16/16	AmeriHealth Caritas deployment team
Develop contract(s)	60 days	Fri 1/1/16	Thu 3/24/16	Vendor Management
Review fees for service(s)	30 days	Fri 3/25/16	Thu 5/5/16	Vendor Management
Negotiate agreements as necessary	30 days	Fri 5/6/16	Thu 6/16/16	Vendor Management
COMMUNICATIONS	**130 days**	**Tue 3/1/16**	**Mon 8/29/16**	
Provider Communications	**130 days**	**Tue 3/1/16**	**Mon 8/29/16**	
Create information	30 days	Tue 3/1/16	Mon 4/11/16	Communications Team
Complete internal review	30 days	Tue 4/12/16	Mon 5/23/16	Communications Team
State review of provider information	40 days	Tue 5/24/16	Mon 7/18/16	Communications Team, Iowa Team
Distribute Information	30 days	Tue 7/19/16	Mon 8/29/16	Communications Team, Information Services

Task Name	Duration	Start	Finish	Resource Names
Internal Communications	**90 days**	**Tue 3/1/16**	**Mon 7/4/16**	
Create information	30 days	Tue 3/1/16	Mon 4/11/16	Communications Team
Complete internal review	30 days	Tue 4/12/16	Mon 5/23/16	Communications Team
Distribute information	30 days	Tue 5/24/16	Mon 7/4/16	Communications Team
REPORTING	**97 days**	**Mon 7/4/16**	**Tue 11/15/16**	
Establish reporting guidelines	30 days	Mon 7/4/16	Fri 8/12/16	AmeriHealth Caritas Deployment Team
Develop reporting workflow	25 days	Tue 8/9/16	Mon 9/12/16	AmeriHealth Caritas Deployment Team
Train Staff to collect data for reporting	25 days	Tue 9/13/16	Mon 10/17/16	Trainers
Generate/review test reports	10 days	Tue 10/18/16	Mon 10/31/16	Information Services
Confirm data meets identified requirements	10 days	Tue 11/1/16	Mon 11/14/16	Quality Director
Launch reporting into production	1 day	Tue 11/15/16	Tue 11/15/16	Information Services
TRAINING	**70 days**	**Mon 8/1/16**	**Fri 11/4/16**	
Define training requirements	20 days	Mon 8/1/16	Fri 8/26/16	Training Manager
Create training workflow	10 days	Mon 8/29/16	Fri 9/9/16	Trainers
Create training documentation	20 days	Mon 9/12/16	Fri 10/7/16	Trainers
Deploy training internal staff and providers as necessary	20 days	Mon 10/10/16	Fri 11/4/16	Trainers
Production date	1 day	Mon 12/5/16	Mon 12/5/16	Iowa/AmeriHealth Caritas Teams
FEEDBACK	**70 days**	**Mon 10/3/16**	**Fri 1/6/17**	
Develop plan to collect participant surveys	30 days	Mon 10/3/16	Fri 11/11/16	Quality Director
Begin collecting responses	10 days	Tue 12/6/16	Mon 12/19/16	Information Services
Review responses	10 days	Tue 12/20/16	Mon 1/2/17	Quality Director
Create response report	3 days	Tue 1/3/17	Thu 1/5/17	IS/Quality
Distribute response reports	1 day	Fri 1/6/17	Fri 1/6/17	Information Services

Task Name	Duration	Start	Finish	Resource Names
10.2.3 Substance Abuse Prevention and Treatment Block Grant.	146 days	Fri 1/1/16	Fri 7/22/16	
IDENTIFY TOPICS - Initiation	**10 days**	**Fri 1/1/16**	**Thu 1/14/16**	
Create working core team, Iowa/ AmeriHealth Caritas	10 days	Fri 1/1/16	Thu 1/14/16	AmeriHealth Caritas Deployment Team
DEPLOYMENT APPROACH	**46 days**	**Fri 1/15/16**	**Fri 3/18/16**	
Identify 17 targeted goal areas	15 days	Fri 1/15/16	Thu 2/4/16	AmeriHealth Caritas Deployment Team
Complete gap analysis, current data available versus requirements	10 days	Fri 2/5/16	Thu 2/18/16	AmeriHealth Caritas Deployment Team
Establish plan to collect missing data	10 days	Fri 2/19/16	Thu 3/3/16	Quality Director
Create workflows	10 days	Fri 3/4/16	Thu 3/17/16	Project team
Begin data collection	1 day?	Fri 3/18/16	Fri 3/18/16	Information Services
COMMUNICATIONS	**55 days**	**Mon 2/1/16**	**Fri 4/15/16**	
Provider Communications	**55 days**	**Mon 2/1/16**	**Fri 4/15/16**	
Create information	10 days	Mon 2/1/16	Fri 2/12/16	Provider Communications
Complete internal review	10 days	Mon 2/15/16	Fri 2/26/16	Quality Director
State review of provider information	30 days	Mon 2/29/16	Fri 4/8/16	Iowa Team, Quality Director
Distribute information	5 days	Mon 4/11/16	Fri 4/15/16	Information Services
Internal Communications	**35 days**	**Mon 2/1/16**	**Fri 3/18/16**	
Create information	15 days	Mon 2/1/16	Fri 2/19/16	Communications Team
Complete internal review	10 days	Mon 2/22/16	Fri 3/4/16	Quality Director
Distribute information	10 days	Mon 3/7/16	Fri 3/18/16	Information Services
REPORTING	**51 days**	**Mon 2/1/16**	**Mon 4/11/16**	
Establish reporting guidelines	5 days	Mon 2/1/16	Fri 2/5/16	Quality Director
Develop reporting workflow	10 days	Mon 2/8/16	Fri 2/19/16	Project team
Train Staff to collect data for reporting	20 days	Mon 2/22/16	Fri 3/18/16	Training Manager

Task Name	Duration	Start	Finish	Resource Names
Generate/review test reports	10 days	Mon 3/21/16	Fri 4/1/16	Information Services
Confirm data meets identified requirements	5 days	Mon 4/4/16	Fri 4/8/16	Quality Director
Launch reporting into production	1 day	Mon 4/11/16	Mon 4/11/16	IS/Quality, Quality Director
TRAINING	**60 days**	**Tue 2/2/16**	**Mon 4/25/16**	
Define training requirements	10 days	Tue 2/2/16	Mon 2/15/16	Training Manager
Create training workflow	10 days	Tue 2/16/16	Mon 2/29/16	Trainers
Create training documentation	20 days	Tue 3/1/16	Mon 3/28/16	Trainers
Deploy training internal staff and providers, as necessary	20 days	Tue 3/29/16	Mon 4/25/16	Trainers
Production date	1 day	Mon 5/2/16	Mon 5/2/16	Iowa/AmeriHealth Caritas Teams
FEEDBACK	**146 days**	**Fri 1/1/16**	**Fri 7/22/16**	
Develop plan to collect participant surveys	1 day	Tue 5/3/16	Tue 5/3/16	IS/Quality
Begin collecting responses	1 day	Wed 5/4/16	Wed 5/4/16	Information Services
Review responses	1 day	Thu 5/5/16	Thu 5/5/16	Quality Director
Create response report	1 day	Fri 5/6/16	Fri 5/6/16	IS/Quality
Distribute response reports	1 day	Mon 5/9/16	Mon 5/9/16	Information Services
10.2.3 Value Index Scores (VIS)	**146 days**	**Fri 1/1/16**	**Fri 7/22/16**	
IDENTIFY TOPICS - Initiation	**20 days**	**Fri 1/1/16**	**Thu 1/28/16**	
AmeriHealth Caritas current review of VIS	20 days	Fri 1/1/16	Thu 1/28/16	AmeriHealth Caritas Deployment Team
DEPLOYMENT APPROACH	106 days	Fri 1/29/16	Fri 6/24/16	
Load historical and current data and map to Treo inputs	30 days	Fri 1/29/16	Thu 3/10/16	Information Services
Load and test data historical data form the state to AmeriHealth Caritas data warehouse	29 days	Fri 3/11/16	Wed 4/20/16	Information Services

Task Name	Duration	Start	Finish	Resource Names
Map current AmeriHealth Caritas data from data warehouse to Treo	15 days	Fri 3/11/16	Thu 3/31/16	Information Services
Send test data feed for historical and current data and test data transmission	1 day	Fri 4/1/16	Fri 4/1/16	Information Services
Evaluate test data feed	**10 days**	**Mon 4/4/16**	**Fri 4/15/16**	
Informatics team review test data feed with Treo	5 days	Mon 4/4/16	Fri 4/8/16	Quality Director
Provide recommendations for modifications/retests	5 days	Mon 4/11/16	Fri 4/15/16	Quality Director
Correct as necessary	10 days	Mon 4/18/16	Fri 4/29/16	IS/Quality
Retesting	10 days	Mon 5/2/16	Fri 5/13/16	Information Services
Production Launch	**30 days**	**Mon 5/16/16**	**Fri 6/24/16**	
Prepare and send 1st monthly feed	5 days	Mon 5/16/16	Fri 5/20/16	Information Services, Project Team
Treo Solutions load data and perform data intake QA	10 days	Mon 5/23/16	Fri 6/3/16	Information Services
Informatics review data intake QA results with Treo	5 days	Mon 6/6/16	Fri 6/10/16	Quality Director
Treo launch VIS dashboard into production	10 days	Mon 6/13/16	Fri 6/24/16	Information Services
COMMUNICATIONS	**30 days**	**Mon 4/4/16**	**Fri 5/13/16**	
Internal Communications	**30 days**	**Mon 4/4/16**	**Fri 5/13/16**	
Prepare internal communications as necessary	10 days	Mon 4/4/16	Fri 4/15/16	Communications Team
Internal communications review	10 days	Mon 4/18/16	Fri 4/29/16	Communications Team, Quality Director
Distribute internal communications as appropriate	10 days	Mon 5/2/16	Fri 5/13/16	Information Services
External Communications	**35 days**	**Mon 4/4/16**	**Fri 5/20/16**	
Prepare external communications as/if necessary	10 days	Mon 4/4/16	Fri 4/15/16	Communications Team
Create documentation	10 days	Mon 4/18/16	Fri 4/29/16	Communications Team

Task Name	Duration	Start	Finish	Resource Names
Review external communications	10 days	Mon 5/2/16	Fri 5/13/16	Quality Director
Distribute external communications as appropriate	5 days	Mon 5/16/16	Fri 5/20/16	Information Services
REPORTING	**56 days**	**Tue 3/1/16**	**Tue 5/17/16**	
Identify additional reporting	15 days	Tue 3/1/16	Mon 3/21/16	Project Team
Create reporting workflow	10 days	Tue 3/22/16	Mon 4/4/16	IS/Quality
Generate test reports	20 days	Tue 4/5/16	Mon 5/2/16	IS/Quality
Review results from test reports	10 days	Tue 5/3/16	Mon 5/16/16	Quality Director
Add reporting to production environment.	1 day?	Tue 5/17/16	Tue 5/17/16	Information Services
FEEDBACK	**38 days**	**Wed 6/1/16**	**Fri 7/22/16**	
Develop plan to collect participant survey's	1 day	Wed 6/1/16	Wed 6/1/16	IS/Quality
Begin collecting responses	1 day	Fri 7/1/16	Fri 7/1/16	Information Services
Review responses	5 days	Mon 7/4/16	Fri 7/8/16	Quality Director
Create response report	5 days	Mon 7/11/16	Fri 7/15/16	IS/Quality
Distribute response reports	5 days	Mon 7/18/16	Fri 7/22/16	Information Services

10.3 Incentive Programs

1. Describe your proposed provider incentive programs.

PerformPlus® (value-based contracting models)

In recent years, significant progress has been made to advance value-based performance models in the Medicare and commercial health insurance markets. However, the Medicaid managed care market has been slower to adopt this model, due in no small part to Medicaid reimbursement fee schedules. With this challenge in mind, AmeriHealth Caritas created PerformPlus to partner with state Medicaid agencies, providers and delivery systems to accelerate the adoption of value-based payment models in the Medicaid managed care market.

PerformPlus is AmeriHealth Caritas' portfolio of value-based incentive programs designed to encourage the "right care" at the "right place." Provider groups, hospitals and integrated delivery systems are rewarded for achieving key performance indicators built around adherence to evidence-based clinical practices and providing cost-effective, appropriate care. Currently, more than 40 percent of our managed

care membership receives care from a provider or delivery system that participates in one or more of PerformPlus' value-based programs.

To support provider performance, PerformPlus provides access to innovative transparency tools that put detailed preventable service activity, care gaps, drug and utilization patterns, clinical population profiles and other data sets in the hands of participating provider groups and delivery systems to facilitate member care management and physician monitoring. This data sharing is principally accomplished through self-service data mining capabilities and comprehensive dashboards that track each metric, which providers can access through a single sign-on to the AmeriHealth Caritas Provider Portal.

PerformPlus programs

PerformPlus offers a number of programs to engage a variety of providers in achieving accountable care and quality objectives. At the foundation, each program seeks to incentivize wellness and chronic care management and discourage unnecessary or preventable utilization; however, the key performance indicators that drive the incentives will be customized to align with Iowa's value-based purchasing goals, as well as the needs of individual practices.

We use both peer- and trend-based performance metrics to determine incentive payments, which come from an established bonus pool of dollars based on a percentage of total volume of claims payment. PerformPlus' risk-adjusted quality metrics include, but are not limited to:

- Potentially preventable hospital admissions.
- Potentially preventable hospital re-admissions.
- Low-acuity emergency room visits.
- Risk adjusted actual and expected utilization measures including ancillary services.
- Neonatal intensive care unit length of stays.
- Obstetric and primary care HEDIS measures.
- Appropriate care measures: the percentage of patients who received recommended treatments based on their clinical condition.

AmeriHealth Caritas Iowa will collaborate with DHS to finalize which programs and which value-based incentives will be offered to providers. AmeriHealth Caritas currently offers the following PerformPlus programs in our health plans:

Quality Enhancement program

AmeriHealth Caritas designed the Quality Enhancement Program (QEP) to reward PCPs, including pediatrics, internal medicine, OB/GYN if participating as a PCP and general/family practice, who deliver:

- High-quality and cost-effective care.
- Member service and convenience.
- Accurate and complete health data.

Performance on the plan's quality indicators is the most important determinant in the program. These quality indicators target specific opportunities for meaningful health improvement, using state quality goals and performance measures as a starting point; they are further refined through analysis of the health plan's data and discussions with health plan PCPs. The QEP is currently live in AmeriHealth Caritas' Pennsylvania and Louisiana plans, which serve more than 600,000 members. The QEP programs in these states use quality indicators such as such as well-child visits, adolescent well-care visits, adult access to preventive and ambulatory health services, maternity care and effective management of patients with

diabetes. Cost-efficiency measures are focused on avoidance of inappropriate use of emergency room services.

We anticipate aligning QEP quality indicators with DHS's performance targets, and leveraging the QEP model to share value-based purchasing incentive payments with Iowa providers. To further support these measures, DHS's performance targets will also be aligned with the member incentives AmeriHealth Caritas Iowa will provide through our CARE Card. AmeriHealth Caritas Iowa will reward members with cash incentives, up to $50 per year, using the reloadable CARE Card. Rewards are accrued as members receive targeted services.

PerformPlus shared savings

AmeriHealth Caritas' signature PerformPlus shared savings program is designed for integrated delivery systems that accept responsibility and accountability for collectively managing a shared population of patients. Based on ACO concepts, shared savings arrangements are intended to address the needs of members in an effective and efficient manner across multiple care settings, eliminating fragmentation and waste in the healthcare system and resulting in better clinical outcomes for the members served.

Currently, AmeriHealth Caritas has shared savings arrangements with partners such as: ACO Pennsylvania (formally Jefferson Health System), Pinnacle Health, Einstein Healthcare Network, Crozer-Keystone Health System, Temple University Health System in Pennsylvania and Christus Health System in Louisiana. Another 14 potential new partnerships are currently being negotiated with health systems such as Penn State Hershey Medical Center and Lehigh Valley Health Network in Pennsylvania, as well as Palmetto Health and the Medical University of South Carolina (MUSC) in South Carolina.

Community Partners program

The Community Partners program is a shared savings program AmeriHealth Caritas designed for FQHCs in collaboration with the National Association of Community Health Centers (NACHC). The program's goal is to reward providers for timely, appropriate ambulatory care and positive patient outcomes by focusing on quality metrics that are impactful to our FQHC partners, such as clinically preventable events.

AmeriHealth Caritas launched the Community Partners program in January 2015 with three FQHCs who serve more than 8,200 members in Pennsylvania and South Carolina. We are currently negotiating with another four potential FQHCs in South Carolina and the District of Columbia.

FQHC Providers Currently Participating	FQHC Providers Currently in Discussion
Quality Community Health Care (PA)	Mary's Center (DC)
Spectrum Health Services (PA)	Care South Carolina, Inc. (SC)
Sumter Family Health Center (SC)	Sandhills Pediatrics (SC)
	Palmetto Pediatrics and Adolescent Clinic (SC)

"The Community Partners program provides us with current, user-friendly data that is easy to access and download. While the program offers a complete incentive, it also provides the tools to do focused patient care management."

Marcella Lingham, M.D., Executive Director, Quality Community Health Centers (PA)

Cardiology program

Built on ACO and medical home concepts, the PerformPlus cardiology shared savings program is designed to promote high-quality care, improve health outcomes and reduce unnecessary/redundant care. The program's quality measures focus on interventions that reduce the risk factors for heart attacks, as well as complications from hypertension and coronary artery disease. Currently, two large cardiology practices in Pennsylvania are participating in the Cardiology program.

Perinatal program

Recognizing that Medicaid plays a key role in child and maternal health, AmeriHealth Caritas has developed a perinatal quality enhancement program that will be implemented in our affiliate health plan in Louisiana and other existing markets in 2015. The program is designed to reward qualifying obstetric practices for improving quality and outcomes measures that support healthy, full-term deliveries, therefore lowering neonatal intensive care unit utilization as well as the rates of medically unnecessary C-sections. Program metrics include pre- and postnatal care, antenatal progesterone administration and sexually transmitted disease screenings, among others.

Women's health program

In addition to the perinatal program, AmeriHealth Caritas is currently developing the women's health program to encourage providers to make timely preventive screenings and preventive care more accessible to female members of one of our Pennsylvania plans. The program will reward providers for screening members for cervical cancer, breast cancer and chlamydia, as well as for improving prenatal care rates.

Custom programs

AmeriHealth Caritas Iowa's advantage is our ability to customize programs based on the needs of each practice. Examples of our customized programs include:

- ACO incentive model (upside only) with Pinnacle Health
  - Incentive compensation is based on Pinnacle Health's claim utilization and quality scores. Rewards higher performance with a larger percentage of shared savings.
  - Per-member-per-month savings.
  - PCP member attribution based on medical claims.
- Full risk model with MUSC (proposed – in discussion)
  - Contains minimum and maximum guardrails. Key outcome is a robust methodology of attributing revenue to a health system.

ACO model

Accountable care organizations (ACOs) are an increasingly popular approach to achieve the triple aim of improved health, better outcomes and lower per-capita healthcare costs. We understand ACO models are

the basis of the SIM program and AmeriHealth Caritas Iowa is ready to partner with the state in supporting this program to bring the next generation of highest-quality care to Iowa's Medicaid population. As a mission-driven managed care organization, our experience in case management, quality reporting and innovative payment design positions AmeriHealth Caritas as a uniquely qualified leader in Medicaid ACO implementations. The business model of an ACO is to align financial incentives with positive patient outcomes and reduce the total cost of care. Population-based value programs grounded in sound methodology are at the heart of our ACO solutions. Our proven products and superior customer service are scalable to any marketplace to achieve accountable care goals, such as higher patient satisfaction, lower healthcare costs and better health outcomes.

ACOs are not a one-size-fits-all solution. Each implementation must be scaled and fine-tuned to the market. As an MCO leading the industry in care management and data analytics, AmeriHealth Caritas is able to implement a tailored ACO solution in Iowa using a multidisciplinary approach based on the unique needs of each market. Our multidisciplinary approach with the Analytic Concierge team and a clinical support team organizes complex information to ensure appropriate care is directed to those who need it most.

Our clinical support team provides services critical to the success of accountable care initiatives, including face-to-face member engagement, care plan development and coordination, appointment scheduling and reminders, identification of gaps in care, community resource connection, member education, behavior change coaching, transportation assistance and other clinical and nonclinical support. Coupled with our innovative payment solutions, such as our Population Value Partnership ACO model, our collaborative approach puts the pieces in place for positive patient outcomes and shared ACO success.

Behavioral health

Our strategy includes a behavioral health (BH) value-based program with the core focus/reward structure centered upon the following;

- Timely follow-up after psychiatric discharge.
- Medication adherence.
- Engagement/treatment.
- Enhanced communication between behavioral health and physical health providers.
- Well care for Serious Mental Illness (SMI) population, includes screenings for diabetes and well-care visits.
- Innovative dashboarding/transparency tools.

When it comes to behavioral health, a member's success is rarely the result of the work done by one doctor or the effectiveness of one procedure. It is a full spectrum of care that offers the best chance of health and full participation in society for people suffering from behavioral issues ranging from alcoholism to depression to schizophrenia. Members have the best outcomes when there is a seamless interaction between emergency care, inpatient treatment, outpatient facilities and social support networks. Unfortunately, the typical payment structure for behavioral health providers is based on services provided, so payment comes per individual treatment session or doctor's appointment. This is a structure that does not encourage the continuum of care that may best suit these individuals.

Evaluation and quality metrics focus on performance in areas such as psychiatric and therapy follow-up, engagement rate, client retention, community treatment, education and medication management. A special focus has been placed on timely follow-ups post-discharge from an inpatient level of care and proactive engagement during outpatient therapy.

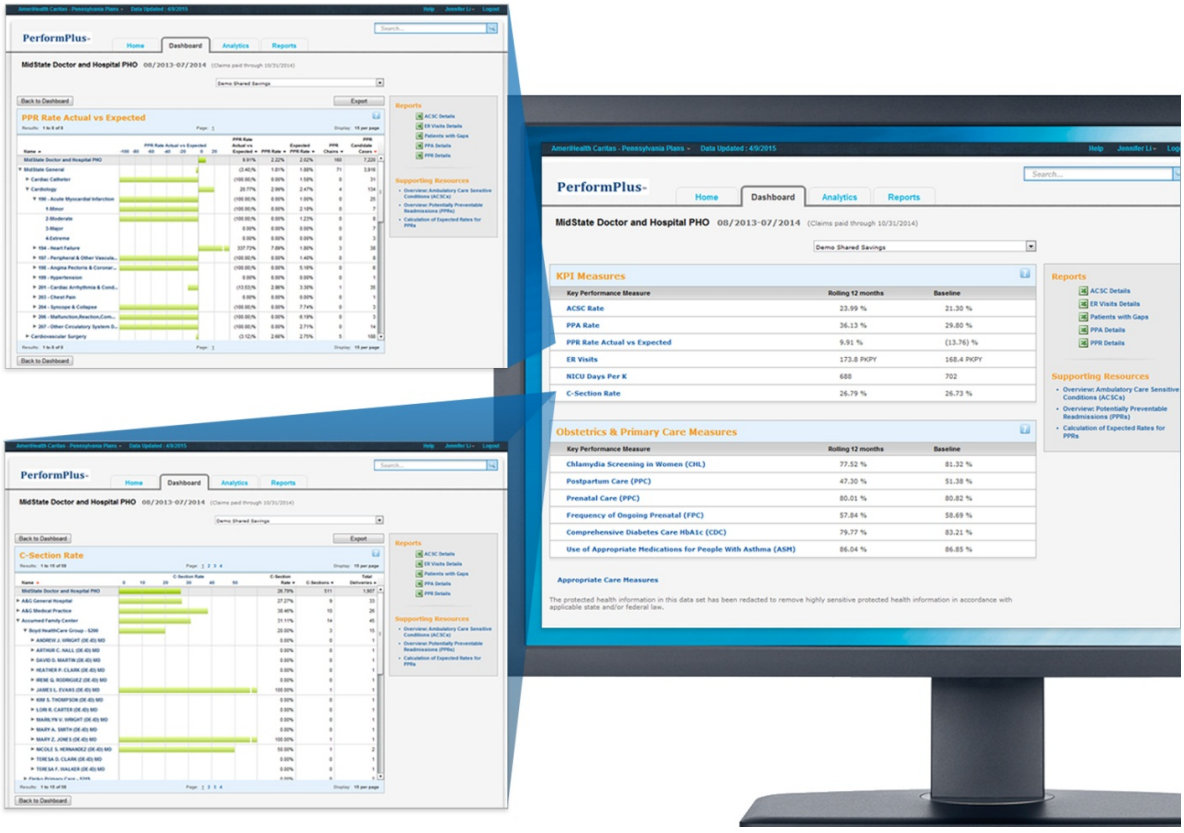
Access to PerformPlus dashboards - moving performance measurement closer to real time

PerformPlus provides a variety of Web-based dashboards to participating providers, enabling them to track their progress for each metric.

Three different dashboards currently exist for our provider partners:

- Shared savings.
- Quality Enhancement Program (QEP).
- Clinical stratification (3M).

Partners participating in the PerformPlus model can access a Web-based dashboard to track their progress for each metric and produce self-service reports and drill-down data mining. The dashboard also allows identification of frequent emergency room utilizers, readmissions, HEDIS results, care gaps, clinical risk and other member-centric data to foster collaboration and meaningful member outreach. Our proprietary PerformPlus dashboard includes all value-based key performance indicators, clinical/risk categorization gaps in care reports and member profiles. Feedback from current PerformPlus shared savings partners has been exceptional. For example, recent comments by Jefferson Health System and Palmetto Health System were that our organization is more advanced than other Medicaid plans and several large commercial payers as well.



"The PerformPlus dashboard provides timely information to monitor our performance and manage our patients, including services provided outside our office."

Susan L. Williams, M.D. President, Crozer-Keystone Physician Partners

A key feature of the dashboard reports is the display of population-level data for all key performance indicators with drill-down capabilities to the facility level, provider level and member level. These detailed reports equip providers with actionable information to quickly identify performance and utilization trends and gaps. The breadth of information on these reports enables providers to better manage their contract and be more accountable to delivering high-quality care to members. This facilitates prompt identification of variation from program goals and will enable the Iowa medical team to meet with individual providers to discuss results, review barriers and assist via brainstorming sessions.

Currently the data reports are based on administrative claims data. We have recently partnered with a cardiology practice to exchange electronic medical record (EMR) data as a limited "use case" pilot. As we continue to enhance our dashboard capabilities, we will seek opportunities to incorporate clinical data from EMR or HIEs wherever possible. Through our participation in health information exchanges in Philadelphia, Washington D.C. and in South Carolina, we will receive additional electronic health record "point of service" quality data over the next 12 to 24 months. This year we are also planning to include authorization data in our monthly dashboard display, to ensure closer to real-time utilization information is available to our provider partners.

2. Describe your proposed member incentive programs.

As discussed in Section 3, The AmeriHealth Caritas CARE Card is an innovation AmeriHealth Caritas Iowa is ready to offer its members in Iowa. We have designed this program to incentivize members for healthy behaviors, which will compound by offering these financial incentives to be focused on elements that will further promote member health and improved outcomes (e.g., CARE Card can be limited to purchasing of healthy foods or other wellness items). We will partner with Iowa DHS to ensure the incentive program targets the state's goals.

We believe this innovation, which has shown positive results in other states, can be an effective service and tool for Iowa's Medicaid members. A recent article in Forbes states that consumer incentives are "one of the rare cases in healthcare when everyone wins. Consumers earn rewards for behavior that improves health or reduces their cost. The system wins by rewarding for behavior that reduces cost."8

Noteworthy examples of widespread programs in other states include:

- Florida's Enhanced Benefits Reward Program — Medicaid consumers earned $15 to $25 credits for compliance with 19 healthy behaviors.
- Minnesota's Well Child/ Immunization Incentive Program— Medicaid members whose physician verifies that their child has received required immunizations, blood lead testing and annual check-ups received Target gift cards.

8 John Nosta. Be Healthy and Get Rewarded--Incentives Driving Engagement. Forbes. April 9, 2014.

- Idaho's Behavioral Preventative Health Assistance Program— Medicaid consumers who consulted with a doctor about losing weight or quitting smoking could earn a $100 voucher, to be used for gym memberships, weight management programs, nutrition counseling and tobacco cessation products.

The federal government — which shares in the cost of Medicaid and establishes program parameters — has also encouraged the utilization of incentive programs. Recently, CMS established the Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) program, which provides funding to state Medicaid programs to test the effectiveness of providing incentives to Medicaid consumers.

10.4 Critical Incidents

1. Describe your critical incident reporting and management system.

AmeriHealth Caritas Iowa will implement the robust critical incident reporting and management system used across other AmeriHealth Caritas health plans. Our system includes a list of triggers and required reporting elements along with time-specific processes for investigation and outcome determination, tracking and reporting.

Critical incidents include but are not limited to adverse, sentinel, never events and/or other circumstances and medical outcomes as described below:

Unexpected mortality	Event resulting in an unanticipated death not related to the natural course of the patient's illness or underlying condition.
Unexpected morbidity	Event resulting in a significant loss of function or further impairment not related to the natural course of the patient's illness or underlying condition.
Fetal demise > 24 weeks gestation	Only those occurring at 24 or greater weeks gestation.
Medication error	Event resulting in an unanticipated death or serious disability associated with a medication error (e.g., wrong drug, dose, patient, time, rate, preparation or wrong route of administration)
Inpatient re-admission ≤ 30 days from an inpatient discharge	Readmission with same or similar DRG/diagnosis that may have resulted from premature discharge or inadequate discharge planning.
Surgical events	• Unplanned removal of organs, injury to organs or body parts during surgery or delivery. • Unintended retention of a foreign object in a patient after surgery, procedure or delivery. • Situations which require return to the operating room or delivery for further operative or delivery procedures. • Any surgical procedures performed on the wrong side, wrong site, wrong body part or on the wrong person. • Intra-operative myocardial infarction/cardiopulmonary arrest.

Unexpected event leading to an increase in the LOS or inpatient stay in hospital	Event that occurred while the patient was being cared for in a healthcare facility that leads to an emergency inpatient admission or additional inpatient days which was reasonably preventable through the application of appropriate evidence-based protocols.
Event related to appropriateness of clinical care	Occurring in any clinical care setting that was related to the failure to follow general practice guidelines.
Facility incidents	Patient death or serious disability associated with a healthcare facility acquired injury from trauma, falls, fracture or burns.
Prolonged fluoroscopy with cumulative dose >1500 rads	To a single field or any delivery of radiotherapy to the wrong body region or >25 percent above the planned radiotherapy dose.
Facility acquired decubitus ulcers stage III or IV	Not present on admission.
Other never events	Event resulting in a patient death or serious disability that occurred while being cared for in a healthcare facility and associated with one of the following: • Patient elopement (disappearance). • A hemolytic reaction due to the administration of incompatible blood or blood products. • An electric shock or elective cardioversion. • Use of contaminated drugs, devices or biologics provided by the healthcare facility. • Use or function of a device in patient care, in a manner in which it was not intended. • Intravascular air embolism occurring while being cared for in a healthcare facility. • Patient suicide or attempted suicide resulting in serious disability. • Hypoglycemia occurring while patient is being cared for in a healthcare facility. • Failure to identify and treat hyperbilirubinemia in neonates. • Patient death or serious disability due to spinal manipulative therapy. • A line designated for O2 or other gas containing the wrong gas or contaminated by toxic substances.

Hospital acquired conditions (HAC) as defined by CMS	• Unintended retention of a foreign object in a patient after surgery, procedure or delivery.
	• Intravascular air embolism.
	• A hemolytic reaction due to the administration of incompatible blood or blood products.
	• Facility acquired decubitus ulcers stage III or IV – not present on admission.
	• Patient death or serious disability associated with a healthcare facility-acquired injury from trauma, falls, dislocations, intracranial injuries, fractures, or burns.
	• An electric shock or elective cardioversion.
	• Surgical site infection following:
	  ○ Coronary artery bypass graft (CABG) – mediastinitis.
	  ○ Bariatric surgery:
	  – Laparoscopic gastric bypass.
	  – Gastroenterostomy – open gastric bypass.
	  – Laparoscopic gastric restrictive surgery – lap band.
	  ○ Orthopedic procedures:
	  – Spinal.
	  – Neck.
	  – Shoulder.
	  – Elbow.
	  ○ Deep vein thrombosis (DVT) pulmonary embolism (PE):
	  – Total knee replacement.
	  – Hip replacement.
	  – Partial hip.
	  – Hip resurfacing.
	  ○ Manifestation of poor glycemic control:
	  – Hypoglycemia.
	  – Hypoglycemic coma.
	  – Diabetic ketoacidosis.
	  – Non-ketotic hyperosmolar coma.
	  ○ Catheter-associated urinary tract infection (UTI).
	  ○ Vascular catheter-associated infection.

2. Describe strategies for training staff and network providers on critical incident policies and procedures.

All AmeriHealth Caritas Iowa staff who interface with members and providers receive training on critical incident reporting as part of their initial orientation. Additionally, appropriate referral for suspected critical incidents is an audit element for Care Management, Utilization Management and Member Service staff. Our ongoing audit processes for these teams continually reinforce the need to take action when an encounter with a member or provider indicates the possibility that a critical incident occurred. Annually, staff from the Quality Management department attend departmental staff meetings to reinforce critical incident scenarios that should be reported and the reporting process.

Provider network account executives train providers on critical incident reporting during provider orientation. Information on the reporting process is also contained in the Provider Manual.

3. Describe processes for implementing corrective action when a provider is out of compliance with critical incident reporting.

Providers who are out of compliance for critical incident reporting are reminded of their responsibilities by the AmeriHealth Caritas Iowa medical director and given a period of 30 days to submit a corrective action plan. The corrective action plan is reviewed by the AmeriHealth Caritas Iowa medical director and a peer-review subcommittee of the QAPIC. The corrective action plan must directly address the finding and offer potential to satisfactorily correct the issue. Updates to the corrective action plan are reviewed through the same process.

Each month the provider involved is reviewed for additional issues or activities related to the finding. Review is ongoing for the following 12 months.

If the provider does not respond to the request for a corrective action plan — or does not follow through on corrective action plan activities — the AmeriHealth Caritas Iowa medical director contacts the provider to explain that continued non-compliance may result in termination. If the provider still does not respond, the AmeriHealth Caritas Iowa medical director initiates AmeriHealth Caritas Iowa's process to terminate the provider in accordance with the provider agreement provisions.

4. Describe how critical incidents will be identified, tracked and reviewed and how data gathered will be used to reduce the occurrence of critical incidents and improve the quality of care delivered to members.

Notification of susptected critical incidents occur through claim review or reports from AmeriHealth Caritas Iowa staff, providers or members. All suspected critical incident notifications are sent to the Quality Management (QM) staff for tracking and investigation. Upon receipt of a suspected cirtical incident notification, the QM staff person opens a secure quality case in the AmeriHealth Caritas Iowa population health management system. A letter is sent to notify the person making the notification that the incident will be investigated and that the outcome is protected by peer-review requirements. Only AmeriHealth Caritas Iowa staff with security privledges to review quality cases have access to quality case type in the system. Information on the date, time and name of the person making the notification are recorded, along with the substance of the report. Critical incident notifications that are sent by mail are scanned and electronically attached to the quality case.

A QM nurse performs the initial review, beginning with the information reported in the notification and other available information in the population health management system. For example, for a critical incident related to an inpatient admission, the QM nurse will review available clinical information collected during the concurrent review and discharge planning process. The QM nurse will request specific additional medical records to conduct a full review.

If it is determined that the delivery of care in the situation led to a potential quality issue, the case and all supporting documentation is reviewed by the AmeriHealth Caritas Iowa medical director or behavioral health clinician. The AmeriHealth Caritas Iowa medical director determines whether the case requires additional follow-up or action, such as provider education or corrective disciplinary action up to and including termination. As warranted or required, AmeriHealth Caritas Iowa also initiates reporting to state and federal regulatory and oversight agencies, such as the National Practitioner Databank in according with AmeriHealth Caritas Iowa's policy on provider sanctioning.

Critical incident reports are monitored, tracked and trended by facility and provider. If a pattern emerges at any hospital, provider office or ancillary provider, our network staff and medical management staff

meet to discuss the findings and plan appropriate action. Results of critical incident review activity and trends are reported to the QAPIC. Additionally, critical incident information associated with individual providers is incorporated in the information gathered during the re-credentialing process.

The outcome of critical incident reviews is also used to drive educational initiatives and program improvements. For example, at AmeriHealth Caritas Iowa's South Carolina affiliate, smaller OB-GYN offices brought a quality of care concern to the health plan concerning sub-optimal use of Tetnus-Diptheria-Pertussis (Tdap) vaccinations for their pregnant adult patients. Under South Carolina state Medicaid policy, the administration of Tdap vaccine to females between the 27th and 36th weeks of pregnancy, had to be performed using vaccine obtained from the physician office. Vaccines obtained from a pharmacy were not covered. This meant that the Obstetrician office had to keep Tdap vaccine in stock for their pregnant Medicaid members. Along with leading to waste when expired vaccines had to be discarded, the providers were not equipped to meet strict state regulations for vaccine oversight and storage. Many of the smaller providers were administering the vaccine at the time of delivery, which provided suboptimal protection for the mother and her child.

To address this issue, the health plan implemented policies at variance with state directives to provide coverage for the Tdap vaccine when dispensed at the pharmacy with a prescription from the physician. A provider communication is in development to promote this new option to the plan's OB-GYN offices. The health plan medical director discussed this initiative with state/regional representatives of several major pharmacy chains who have agreed to distribute information to all state pharmacies.

10.5 Provider Preventable Conditions

1. Describe how you will ensure payment is not made for provider preventable conditions.

Per AmeriHealth Caritas standard operating policies and procedures, healthcare acquired conditions (HCAC) and other provider-preventable conditions (OPPC) diagnoses claims are automatically reviewed prior to any payment. If a billed service is found to be HCAC or OPPC, providers are not paid and the claim is denied. If a subsequent review identifies a HCAC or OPPC that may not have been coded as such, an internal claims team that specializes on these types of claims executes a take-back to have the funds deducted from the next provider payment. AmeriHealth Caritas Iowa's payment policy with respect to provider preventable conditions (PPC) complies with the Patient Protection and Affordable Care Act of 2010 (ACA).

Ensuring non-payment for claims involving an OPPC

In addition to broadening the definition of OPPCs, the ACA requires payors to make pre-payment adjustments. That is, an OPPC must be reported by the provider at the time a claim is submitted. There are some circumstances under which an OPPC adjustment will not be taken, or will be lessened. For example:

- No payment reduction will be imposed if the condition defined as an OPPC for a particular member existed prior to the initiation of treatment for that member by the provider. Please refer to the "Reporting a Present on Admission" section for details.
- Reductions in provider payment may be limited to the extent that the identified PPC would otherwise result in an increase in payment; and AmeriHealth Caritas Iowa can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to the PPC.

Example of policy: In-patient facility

When an OPPC is not present on admission (POA) but is reported as a diagnosis associated with the hospitalization, the payment to the hospital will be reduced to reflect that the condition was hospital-acquired**.** When submitting a claim which includes treatment as a result of an OPPC, facility providers are to include the appropriate ICD-9 diagnosis codes, including applicable external cause of injury or E codes on the claim in field 67 A – Q.

For per-diem or percent of charge based hospital contracts, claims including a PPC must be submitted via paper claim with the member's medical record. These claims will be reviewed against the medical record and payment adjusted accordingly. Claims with OPPC will be denied if the medical record is not submitted concurrent with the claim.

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11. Utilization Management

Please explain how you propose to execute Section 11 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Overview

AmeriHealth Caritas Family of Companies' (AmeriHealth Caritas) Utilization Management (UM) program is designed to ensure that members receive appropriate, evidence-based care. We collaborate with providers, members and others involved in healthcare delivery, to provide quality, cost effective physical health, behavioral health and long-term services and supports (LTSS) in the most appropriate setting for the intensity of services required.

Our UM program ensures that the intensity and duration of services requested and provided are consistent, medically necessary and clinically appropriate to the individual, and match the member's health status and current needs.

AmeriHealth Caritas' UM program objectives include:

- Facilitating the reduction of inappropriate and duplicative healthcare services.
- Promoting collaborative practice among all disciplines to assure continuity of care and high-quality services over the course of illness and recovery.
- Fully integrating physical health, behavioral health and LTSS services so as to minimize fragmentation in service delivery.
- Ensuring that medically necessary care and services are provided in the most appropriate clinical mix, intensity and duration, consistent with the member's condition and needs.
- Ensuring that physical health, behavioral health and LTSS are medically necessary and delivered to the member at the least restrictive and most appropriate level with a length of stay that is clinically indicated.
- Promoting appropriate interventions, alternatives and care management programs as healthcare services are rendered.
- Facilitating the identification and management of high-risk cases, with appropriate referral of high-risk management cases to the Integrated Healthcare Management (IHM) department.
- Reviewing and evaluating member and provider satisfaction with AmeriHealth Caritas Iowa's UM program.
- Assessing utilization practices and patterns to identify over- or under-utilization of services by providers and members and review outliers.
- Reviewing and rendering determinations for provider and member appeals of medical necessity determinations.

AmeriHealth Caritas Family of Companies (AmeriHealth Caritas) uses InterQual® criteria and employs a rigorous clinical policy development and evaluative process to support UM activities. Additionally, AmeriHealth Caritas will publish its evidence-based clinical policies on AmeriHealth Caritas Iowa's public

website to demonstrate the transparency of its standards to members and the provider network. Public comment opportunities are available for these clinical policies.

AmeriHealth Caritas Iowa's UM programs ensure that the intensity and duration of services requested and provided are consistent, medically necessary and clinically appropriate to the individual, and match the member's health status and current needs. Efforts are made to obtain all necessary information to appropriately review the member's condition and to make determination for authorization of care. Reasons for decisions are clearly documented and provided to the member. All components of UM are monitored and evaluated for continuous quality improvement.

AmeriHealth Caritas mines administrative data to identify new opportunities for UM activities and to evaluate the effectiveness of its programs. For example, when new medications were introduced to treat Hepatitis C, AmeriHealth Caritas implemented American Association for the Study of Liver Disease (AASLD) guidelines, then developed stricter evidence-based guidelines and obtained state approval to implement them. Our guidelines have been revised five times in the last year as the science and recommendations changed. Improvement in adherence to guidelines is near 100 percent and the costs of medications have declined by over 80 percent.

UM activities and results are reported to committees in the Quality Assessment and Performance Improvement Committee (QAPIC) structure and include utilization monitoring activities as described in the Quality Assessment Performance Improvement (QAPI) work plan. UM program policies and procedures meet National Committee for Quality Assurance (NCQA) standards and are reviewed and updated as needed and at least annually. As in all of our markets, externally practicing Iowa physicians will sit on the AmeriHealth Caritas Iowa Quality of Clinical Care Committee (QCCC) Committee and QAPIC, so that external Iowa physicians will have a voice in providing oversight for these activities.

AmeriHealth Caritas consistently meets the timeliness standards for UM review as required by each of the states in which we operate and by NCQA. AmeriHealth Caritas Iowa will comply with all requirements stated within this section and any new technical requirements established by the State of Iowa and developed through the collaborative process outlined in the Scope of Work.

AmeriHealth Caritas Iowa will comply with all needs stated within this section, including areas not specifically addressed in the questions below.

11.1 Utilization Management Programs

1. Describe in detail your utilization management program, including how you will operate and maintain the program.

AmeriHealth Caritas successfully operates UM programs for all of our health plans that incorporate evidence-based policies and procedures in a comprehensive, systematic approach to ensuring delivery of the right service at the right time in the most cost-effective manner. The AmeriHealth Caritas Iowa UM program will incorporate nationally recognized InterQual guidelines, regular and ongoing evaluation and comprehensive associate training, and inter-rater reliability (IRR) testing to ensure that our membership in Iowa receives high-quality, medically necessary care. For new technologies and certain high-cost/high-volume services, AmeriHealth Caritas Iowa will also incorporate a disciplined, evidence-based process to decide which procedures require prior authorization, and implement supplemental evidence-based clinical policies, as needed, to address them.

Access to UM staff

A registered nurse and physician will be immediately available by phone 24 hours a day, seven days a week, to render UM determinations for providers and members. For routine utilization-related inquiries, AmeriHealth Caritas Iowa UM staff will be accessible to members and providers via mail, toll-free phone, online portal and fax Monday through Friday, with the exception of recognized and agreed-upon holidays. Plan business hours will be 8:30 a.m. to 5:00 p.m. CST.

An AmeriHealth Caritas Iowa medical director and behavioral health medical director are available within one business day (or immediately in urgent/emergent cases) to discuss a medical necessity determination with the attending physician or other ordering provider.

UM resources

The AmeriHealth Caritas Iowa medical director, an Iowa-licensed physician, is responsible for the development, implementation and oversight of all aspects of the AmeriHealth Caritas Iowa UM program. Day-to-day operations for the UM program are managed by the director of UM.

The roles of each of the staff members in the UM program are clearly delineated to ensure all aspects of the UM process work in harmony and promote access to high quality, medically necessary healthcare services. Specific roles and responsibilities are documented in role-specific job description documents.

Requests for benefit coverage or medical necessity determinations are made through staff supervised by a registered nurse or licensed behavioral health clinician. Decisions to approve coverage for care may be made by the UM staff when they fall within AmeriHealth Caritas Iowa's written guidelines.

Licensed physicians and psychologists support the nurses and behavioral health clinicians within the UM department. AmeriHealth Caritas Iowa medical directors provide clinical review of medical information and/or direct peer-to-peer contact with attending physicians when there is conflicting medical information or if there are questions on the application regarding medical necessity criteria related to requests for coverage of medical services. All AmeriHealth Caritas Iowa medical directors, behavioral health physicians and psychologists involved in medical necessity decisions will be licensed in Iowa.

Medical necessity decision making

Any request that is not addressed by, or does not meet, medical necessity guidelines is referred to the medical director or behavioral health physician/psychologist for a decision. Any decision to deny or limit coverage for an admission, service, procedure or extension of stay, based on medical necessity, is made by a medical director, behavioral health physician or psychologist or another designated physician under the clinical direction of the medical director.

Medical necessity decisions made by a medical director, behavioral health physician or psychologist are based on the Iowa Department of Human Services' (DHS') definition of medically necessary services, in conjunction with the member's benefits, medical expertise, medical necessity criteria and/or published peer-reviewed literature. At the discretion of the medical director, a behavioral health physician or psychologist, participating board-certified physicians or behavioral health clinicians from an appropriate specialty may provide input to the decision. The medical director, behavioral health physician or psychologist makes the final decision.

AmeriHealth Caritas Iowa will not retroactively deny reimbursement for a covered service provided to an eligible member by a provider who relied on written or oral authorization from AmeriHealth Caritas Iowa or an agent of AmeriHealth Caritas Iowa, unless there was material misrepresentation or fraud in obtaining

the authorization. Upon request by a member or participating provider, the criteria used for medical necessity decision making in general, or for a particular decision, is provided in writing by the medical director, behavioral health physician or psychologist.

The UM associates and medical directors, behavioral health physicians or psychologists involved in medical necessity decisions are assessed annually for consistent application of review criteria. Variances among associates in each functional group are identified and corrective action is implemented.

Technology assessment and clinical policy development

AmeriHealth Caritas Iowa will use a disciplined, evidence-based process to evaluate new technologies and medical services, and to decide which procedures require prior authorization. Our clinical policy development process is based on in-depth review of the medical literature using the criteria for strength of evidence employed by the federal Agency for Healthcare Research and Quality (AHRQ). The clinical policy review process recognizes the strength of evidence and the potential for bias in the evaluation of the medical literature. These clinical policies are reviewed annually or more frequently as new scientific knowledge emerges. The Clinical Policy Committee reviews the draft reports over a two-month period before approval. The Iowa DHS will have the opportunity to review the clinical policies prior to their adoption. Additionally, the draft clinical policies will be posted to the AmeriHealth Caritas Iowa provider website for public comment prior to the effective date. The approved clinical policies are employed during the course of UM as a key tool in the evaluation of requests for new technologies and medical services. AmeriHealth Caritas Iowa monitors the cost of new technologies and medical services while reviewing the quality of care impact to members, such as complication rates and reduced hospitalizations resulting from these new technologies and services.

As an example, AmeriHealth Caritas Iowa's affiliate in South Carolina was approached by two bariatric surgeons to add coverage for gastric sleeve surgery. At the time, the procedure was not eligible for payment on the State's Medicaid fee schedule. The surgeons explained that the procedure had lower short- and long-term complication rates. After investigating available evidence, including input from the practicing providers, the health plan agreed to cover the procedure and facilitate billing through a miscellaneous code. The plan also assisted the surgeons in successfully lobbying the State to add the procedure to the Medicaid fee schedule.

Integration of AmeriHealth Caritas Iowa programs within UM

AmeriHealth Caritas Iowa will use a streamlined process that leverages prior authorization information as an inspection point in situations of high-cost services and wide variations in the medical community of service utilization. Our approach includes a move toward more algorithms to automate predictable decisions through fewer required prior authorizations. Our Medical Economics department will monitor data for outliers. Additionally, we have implemented a combined Pharmacy and Therapeutics Committee with representation from all of our health plans that will monitor the pharmacy review process. Using corporate analytic support, the AmeriHealth Caritas Iowa team will integrate areas of utilization focus with AmeriHealth Caritas Iowa's other IHM and value-based payment programs. Examples of such integration include:

1. PerformPlus® enterprise-wide value-based contracting solutions for primary care, specialty care, facilities and accountable care organizations (ACOs) that demonstrated the effectiveness of taking a metrics driven, collaborative approach to network contracting. AmeriHealth Caritas' experience demonstrates that when data-driven information is given to providers, the providers' recognize

opportunities for improvement and find ways to improve the efficiency of appropriate medical services utilization.

2. Numerous embedded care manager initiatives, including care managers in office sites, care managers in emergency rooms (ER) (Acute Care Transition program), community-based care connectors and care managers, identify unmet member needs and facilitate needed services. We successfully use this approach in all of our markets to decrease episodes of avoidable care.
3. In New Jersey, PerformCare is an advocate and active participant with the New Jersey Children's System of Care (CSOC). As the administrative service organization (ASO) for the State of New Jersey's Division of CSOC since 2009, PerformCare utilizes significant expertise and integrated technologies to register, authorize and coordinate services for children, youth and young adults who are experiencing emotional and behavioral challenges or are developmentally and intellectually disabled. PerformCare provides UM for all authorizations of clinical services for youth in the New Jersey CSOC.

The programs implemented by PerformCare New Jersey decreased out-of-state behavioral health placements from a total of 327 in 2006 to zero in 2015. At one time, 53 percent of youth involved in out-of-home placements through the child welfare system were out -of -state, complicating opportunities for family engagement. By expanding community-based and intensive in-home therapeutic services, including care management, youth have been successfully treated in less restrictive settings. The number of youth served by care management has grown from nearly 7,000 youth in 2000 to over 44,000 youth in 2013, an increase of more than six-fold.

Similarly, the total number of youth treated in out-of-home behavioral health settings in New Jersey has decreased from a total of 3,749 youth in 2007 to 3,100 youth in 2013, a decrease of 17 percent. The decrease in out-of-home treatment from 2009 to 2013 has been 9 percent. The number of admissions to out-of-home settings has decreased between 2012 and 2014 by 16 percent.

The average length of stay in out-of-home behavioral health (residential) treatment settings has decreased 27.5 percent between 2012 and 2014. The decrease in length of out-of-home stay is a positive outcome, indicating that the youth are returning to community settings sooner. Also, nearly 80 percent of youth remained in community settings during the first year after discharge from out-of-home treatment based on 2013 discharge data.

PerformCare clinical coordinators approve authorizations for mobile crisis dispatches after a highly structured telephonic triage process with the youth and family. Mobile crisis arrives to the home of the youth and family typically within one hour of the authorization. When the care coordinator identifies a more emergent crisis, police are dispatched and/or youth are referred directly to the local ER or psychiatric screening center. Through the initial authorization of mobile crisis (for 72 hours), as well as authorization for mobile crisis stabilization services (up to eight weeks), 96 percent of the youth served remain in the community, avoiding costly hospitalization, and 98 percent of the youth served remain in the home setting, avoiding costly out-of-home residential treatment. Clearly, the outcomes for youth accessing mobile crisis services are extremely positive.

Outcome monitoring and ongoing evaluation

Evaluation of our UM program is conducted through retrospective statistical analysis and ongoing, consistent evaluation and monitoring. Program components are evaluated retrospectively to both identify positive outcomes and to identify “markers” of success that are incorporated both in future UM initiatives and monthly care management identification algorithms. Evaluation is conducted using sophisticated statistical techniques applied to a combination of medical, pharmacy, survey data, HEDIS measure results, risk stratification scores, eligibility and other data points critical for meaningful population health study.

Propensity matched cohorts are identified to isolate the true statistical impact relative to the program study group. Trend improvement is also studied for different services managed through UM techniques and statistical significance is calculated to ensure that each program studied is evaluated for true positive impact, normalized for the trend effect of the larger, non-study population.

Using the tools and resources of its corporate parent, AmeriHealth Caritas Iowa will continually refine its approach to outcome monitoring and program evaluation. We employ a "proactive analytic learning model" to consistently monitor, evaluate and refine programs. Utilizing this approach, we are able to systematically evaluate disparate metrics in a meaningful way to assess the success of UM activities, thereby building a more refined UM program based on predicted attributes of success. As specific metrics are identified to be more or less predictive of high levels of success, the proactive analytic learning model scoring algorithm is modified to reflect these learnings. New data may be added while other less outcome-driven information may be removed as the model is enhanced and refined over time. This constant feedback loop of information yields an effective, dynamic process for ongoing refinement our activities.

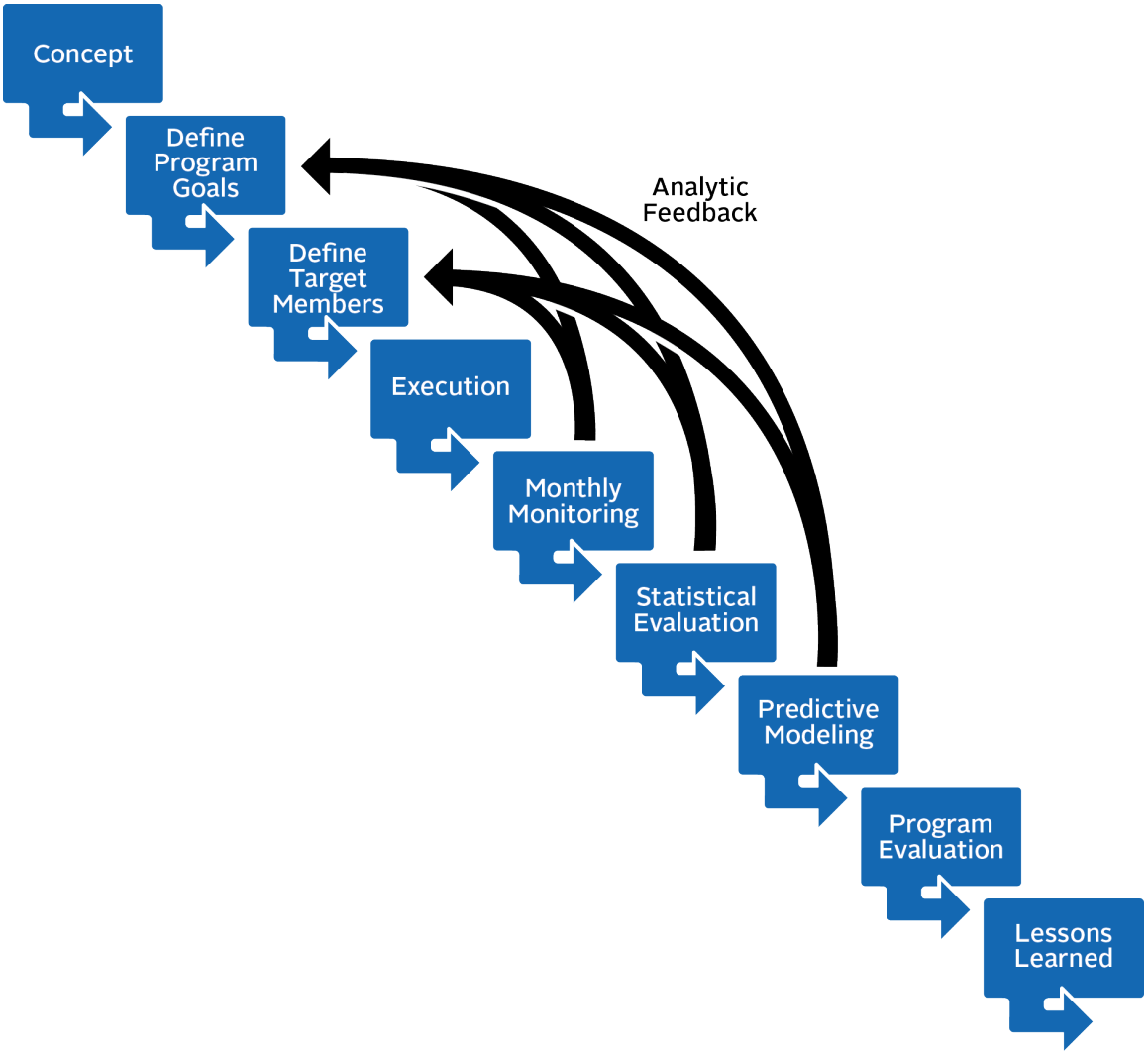

Exhibit 11.1-A: UM Feedback Loop

We are currently using this approach with our Community Care Management Team (CCMT) program to refine how we engage members into the program to have greater success of effective management and early intervention of "super utilizers." When the program began in 2013, members were identified based on over-utilization analysis (high-volume inpatient and ER utilization), physician referrals, care manager referrals and the presence of multiple chronic conditions. The member engagement rate was 15 percent. In 2014, using the learning model, we refined how members were identified for the program by using historical data to rank key attributes, such as total medical spend, number of inpatient admissions, number of ER visits, and so forth, to target members by subsets for intervention. With this approach, the member engagement rate increased to 53 percent. The program lead immediately changed how members are targeted for outreach. The CCMT program results are promising with reductions in average per-member-per-month total medical spend, inpatient claims and ER claims. Our next step is to develop predictive models based on trends to further refine member target population. The learning model is an iterative process, and one which we believe will produce actionable data and continuous refinement of our programs. We will continue to use this model because we understand the value of efficient front-end performance in reducing costly and inefficient back-end work and reducing the administrative burden on providers.

2. Describe your policies, procedures and systems to:

a. Assist utilization management staff to identify instances of over- and under-utilization of emergency room services and other healthcare services;

AmeriHealth Caritas Iowa will utilize AmeriHealth Caritas' proven methods to assist staff in the identification of over- and underutilization of healthcare services, including ER services. We use a variety of techniques, including care gap alerts, a 360-degree view of all member care through our population health platform and training on the identification of potential fraud, waste and abuse cases. We have a strong focus on ensuring members are connected to integrated primary care so that their needs can be addressed without the need for an ER visit.

Care gap alerts

Care gaps occur when members do not receive (or there is no documentation that they received) services recommended by evidence-based clinical practice guidelines. AmeriHealth Caritas analyzes claims data against evidence-based algorithms monthly to identify gaps in care. Care gap algorithms exist for a full range of preventive services and chronic disease states. Connecting the member with needed care identified through the care gap process can avoid under-utilization of critical healthcare services.

Care gap alerts, are available to associates performing UM, quality management, care management and member services activities. Associates see a system flag when the member's identification (ID) number is entered.

Providers also receive care gap reports, both as alerts during an eligibility check, and as full panel reports through the Provider Web Portal. When the member's ID number is entered in the Provider Web Portal, a pop-up alert appears notifying the provider that a care gap exists. When the provider clicks on the alert, a member-level report appears, identifying missing and overdue services, care gaps and up-to-date services. The provider can also access a report of all care gaps for his assigned members, either as a printable document or as a comma-separated values (CSV) file that can be incorporated into other systems.

Complete view of member's services through "Member 360"

We have built our data infrastructure in a way that allows our staff a complete view of all available clinical information and services a member has a received. Data available through our population health management system include information on prescription refill dates, ER visits, inpatient admissions, laboratory results and other physician and outpatient services the member is currently receiving or has received in the past. This allows easy identification of potential over-use and under-use of services.

Through ongoing claim analysis, Jake, a 15-year-old boy, was identified for an in-depth care management assessment. Diagnosed with hypertrophic cardiomyopathy, Jake had three hospital admissions since his diagnosis in 2013 and was not getting regular refills of his medications. After unsuccessful attempts to contact Jake's parent via phone, searches for alternate contact information and a follow-up letter, the care manager sent a care connector from the Community Outreach Solutions (COS) team to connect with Jake at his home. The COS associate found Jake's mother at home and connected Jake and his mother with the AmeriHealth Caritas care manager.

The care manager quickly identified that Jake was supposed to be re-evaluated by his cardiologist but had not made an appointment. Using a three-way call, the care manager and mother called the cardiologist office together and set up the appointment. The care manager also contacted the pharmacy to have Jake's spironolactone refilled.

After addressing Jake's initial needs, the care manager administered the PHQ9A to screen for depression. Jake's results indicated potential mild depression. In reviewing the results with Jake, he indicated that he would like to talk with someone about how he was feeling and the care manager provided information on behavioral health resources in Jake's area. The care manager also helped Jake's mother find a new dental provider near their home to address Jake's routine dental care gap and provided information to get Jake connected to the state transportation vendor to give Jake an alternative to the public transportation currently used for medical appointments.

Additionally, proprietary analytics are able to mine our data sets for unmet member needs and potential duplicative care or overuse. Information on member needs is fed back into our population health management system and queued as a work list activity for a member of the care management team to address. For example, a member who is identified as pregnant through analysis of claim data is flagged for outreach by a Bright Start® pregnancy management care connector to ensure that all needed prenatal care is delivered.

Developing innovative solutions to address underutilization

AmeriHealth Caritas recognizes that laboratory test results drive many health care decisions, but the process in obtaining the results can be scary, intimidating, inconvenient and expensive. It is estimated that between 40-60 percent of laboratory tests are not completed, which means that individuals and their health care providers likely do not have all the right information at the right time to make important health care decisions or develop comprehensive care plans.

Typically, health care innovation and technology is first available to individuals who are most advantaged. Our partnership with Theranos provides an opportunity for us to bring an innovative solution to those who are least advantaged first, giving them a health care experience that reinforces our approach to treating all members with dignity and respect.

Theranos is a CLIA-certified laboratory that offers services for a complete range of tests from common blood screening panels to specialized testing across all specimen types. Their revolutionary laboratory service platform uses dramatically smaller samples than traditional labs, with samples collected from both capillary draws and traditional methods. Results are returned much faster than industry averages, with the overwhelming majority of results reported within 24 hours of sample collection. The process for utilizing Theranos services is consistent with what providers and patients are accustomed to today, with improvements to enhance the ease of each step.

Removing barriers to health care and services for those most in need is a top priority for our family of companies. We believe that we are the first Medicaid managed care organization in the nation to bring this innovative, evidence-based and customizable solution to our members and providers. It is important that our members and their health care providers have the information they need, when they need it, to develop personal health care plans and make health care decisions, and so members can fully engage in their health care.

Our partnership with Theranos is aligned with our mission, consistent with our commitment to offer solutions to assist our clinical partners, and supports our forward-thinking approaches to developing innovative solutions for our members and providers.

Fraud, waste and abuse investigations

All of our associates receive training on fraud, waste and abuse (FWA) to identify potential over-use and misuse of healthcare services. Our training program includes didactic material and competency testing to ensure that associates understand the content. UM associates routinely report identified concerns to the Special Investigations Unit (SIU) for investigation and action. We also maintain a FWA hotline and reporting capability through our internal Web portal.

We are armed with FWA software and reporting that also helps identify issues. The SIU routinely analyzes utilization data to identify provider and member patterns potentially indicating overuse, misuse or underuse of services. For example, a provider billing for in-office laboratory services for every patient seen in the office may indicate over-use of services.

Case studies:

Overutilization

We monitor utilization patterns at the member level and then aggregate them to look for patterns on the provider level. Through this review process we identified a new provider whose payments from us had increased over 1,000 percent from 2012 to 2014 in one of our Midwest states. Based on this information, we scheduled a visit with the provider to ascertain the services being provided and understand the significant increase. The visit demonstrated that the services being provided were medically necessary the majority of the time. However, it was also determined that the provider was conducting educational activities during that time and billing them as clinical program time. This finding resulted in a referral to the FWA unit where the investigation is continuing.

Underutilization

In a Midwest state, we determined that many members were not being seen by a mental health professional within seven days of discharge from a mental health inpatient hospitalization. This resulted in a low HEDIS Follow-Up after Hospitalization for Mental Illness (FUH) score and a high readmission rate. One of the many interventions we implemented involved contracting with mental health professionals to provide this follow-up visit in the member's home within one to two days of discharge. This intervention resulted in a significant increase in our HEDIS FUH rate, reduction in readmissions and confirmation that our members are now being safely maintained in the community.

b. Analyze emergency department utilization and diversion efforts.

AmeriHealth Caritas has developed a comprehensive strategy to avoid unnecessary use of the ER, using a variety of interventions to address the unique socioeconomic and cultural characteristics that influence how our members access care. Through initiatives such as outreach to members with high ER utilization and proactive member education, we have worked to curtail the rise of ER overuse in our membership. We will implement these programs in Iowa.

Overuse of the ER is a well-documented national problem that transcends all demographic groups and is particularly acute within the Medicaid program. In the 16-year period ending in 2011, the number of ER visits in the United States increased over 41 percent from 96.5 million to 136.3 million, according to the Center for Disease Control and Prevention. The number of visits by Medicaid recipients is almost two-fold those seen in the Commercial population and most of the visits are for urgent issues, which suggests many have health needs that are not being adequately addressed in lesser care settings910.

Inappropriate visits continue to rise sharply. Visits made to the ER for a condition that does not require emergency treatment is a concern across the country. According to Health Leaders, only 29 percent of patients presented with an emergent condition that was not avoidable. Conversely, 24 percent presented with no emergent medical need at all. Among those who showed up in the ER and had an emergent condition, 42 percent could have been treated in a primary care setting and six percent could have avoided the ER trip with timely outpatient care. Diversion of just 10 percent of patients who did not have an unavoidable emergent medical need could result in a net savings of $18.68 in total allowed costs per-member per-year, totaling over $7.6 million for a population of 400,000.

The 2007 Institute of Medicine publication, "Hospital-Based Emergency Care – At the Breaking Point," reported that Medicaid patients use the ER twice as often as the uninsured, and four times as often as those with commercial insurance. The challenge of reducing inappropriate ER use in a Medicaid population is complex and requires a multifaceted approach.

Our approach is aligned with Iowa's priority of establishing a true medical home for members, aligning provider reimbursement with desired health outcomes and moving from an episodic care model to a comprehensive chronic care model to address the needs of members with chronic illness. Our experience

9 Garcia et al. 2010. Emergency Department Visitors and Visits: Who Used the Emergency Room in 2007? CDC, NCHS Data Brief No 38.

10 Sommers et al. 2012. Dispelling Myths About Emergency Department Use: Majority of Medicaid Visits Are for Urgent or More Serious Symptoms. Center for Studying Health Systems Change.

has shown that such measures, in combination with appropriate care management for those with chronic conditions, drive reductions in inappropriate ER use.

Emergency room initiatives

Reduction of inappropriate utilization of the ER is a key focus of AmeriHealth Caritas UM activities. We will tailor our interventions to fit with Iowa's healthcare delivery resources and complement existing programs. We will concentrate our initiatives on identification of frequent ER users, building strong care management relationships in that population, educating all members on when to use the ER versus the primary care physician (PCP) or an urgent care center and encouraging self-management of non-emergent issues.

AmeriHealth Caritas will regularly review ER utilization reports to identify the underlying issues causing members to seek emergency care. Often, we find that members who frequently use ER services have behavioral health conditions. Our care managers will reach out to these members to assess their needs and attempt to connect those with reported or suspected behavioral health needs to appropriate behavioral health services. In addition, the care manager may become aware of potential or actual behavioral health needs through predictive modeling, assessment or during routine care coordination activities.

Our experience has shown that our interventions, described below, in combination with appropriate care management for those with chronic conditions, drive substantial reductions in inappropriate ER use. We use a portfolio of initiatives in our other markets to combat ER overuse and will employ many of these initiatives in Iowa, including:

- **Data-driven Outreach —** AmeriHealth Caritas uses claim data to identify frequent ER users. Our Rapid Response team contacts identifies members by phone to offer education and assistance in finding appropriate primary and specialty care and reinforce appropriate use of ER services. We also receive daily reports from the nurse triage vendor detailing members who called the service in the previous 24 hours, the problem identified and the advice given. Rapid Response care connectors contact the member to check the outcome of the advice they received, assess for unmet needs and connect the member back to the PCP through an appointment.

  Our affiliate in Louisiana used this approach with the top 100 ER utilizers in that plan. The chart below demonstrates the results for the cohort of identified members we started in January of 2014, and by February, the number of ER visits for the cohort declined drastically. Despite a slight increase noted in March, the trend continued to show a consistent decline in the April, May and June. Overall in the six-month period, there was a 65 percent reduction in the number of ER visits for this group of members. This is a result of aggressive, targeted outreach by the Rapid Response team.

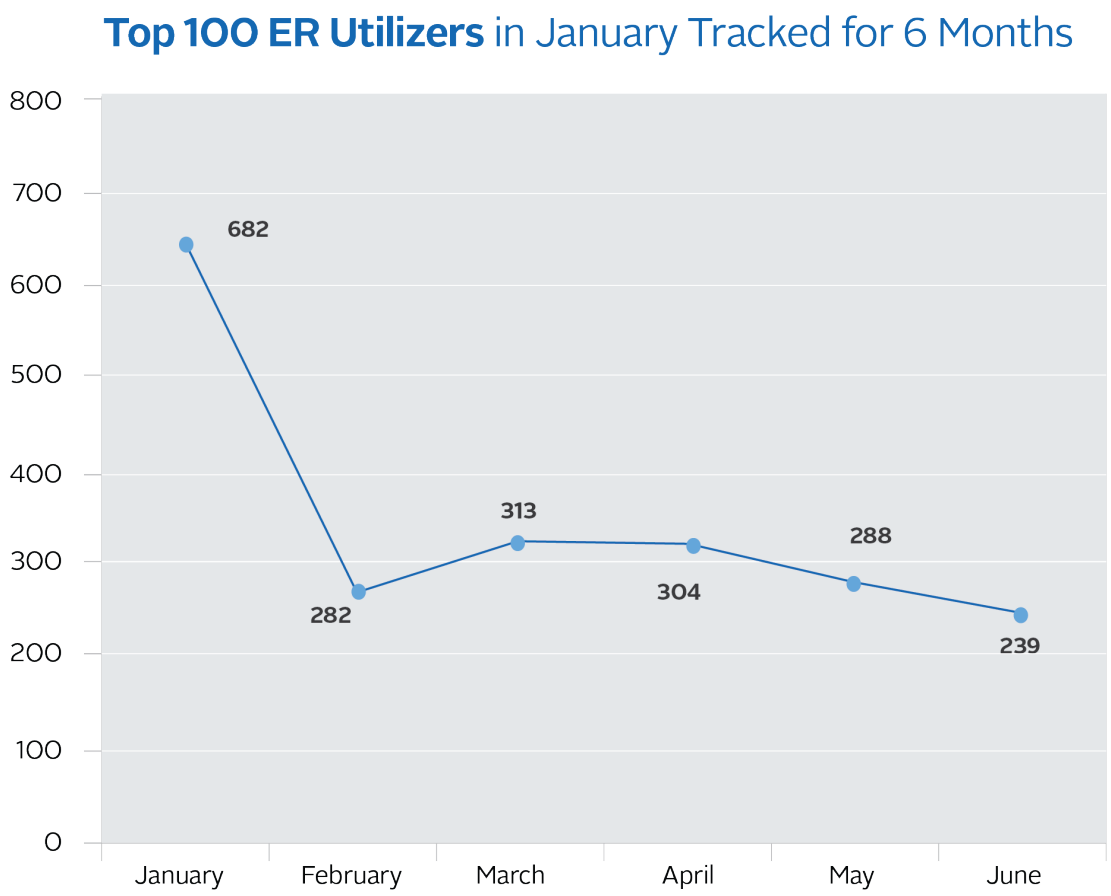

Exhibit 11.1-B: ER Utilization Example

- **Acute Care Transition Managers** — We place care management resources in the ERs of our high-volume facilities. Through personal contact with ER users during the ER event, we are able to confirm the member's contact information for post-ER follow-up. We are able to conduct an onsite assessment of the barriers and drivers that led the individual to the ER. We also use the opportunity to strengthen the care management relationship with the member, make an appointment with the PCP and forward the ER discharge summary to the PCP's office.
- **Quality Incentive Programs for Providers** — Our quality incentive programs include metrics on ER use, specifically focusing on Potentially Preventable Visits (PPVs). Provider performance is risk-adjusted and compared to a cohort of peer providers and historic performance, and influences quality of incentive payments to providers.
- **For Your Kids Care** — We run community education programs to educate parents of young infants on how to care for sick children, effective home treatments and when to seek medical or emergency care. Interested participants can become lay instructors for the program. Each participant is given an easy-to-read reference book outlining symptoms and recommended care for common childhood illnesses. We also supply thermometers to those participants who don't have them. We learned early in the program that the advice regarding fever in the book will not help a parent who has no means to take the child's temperature.

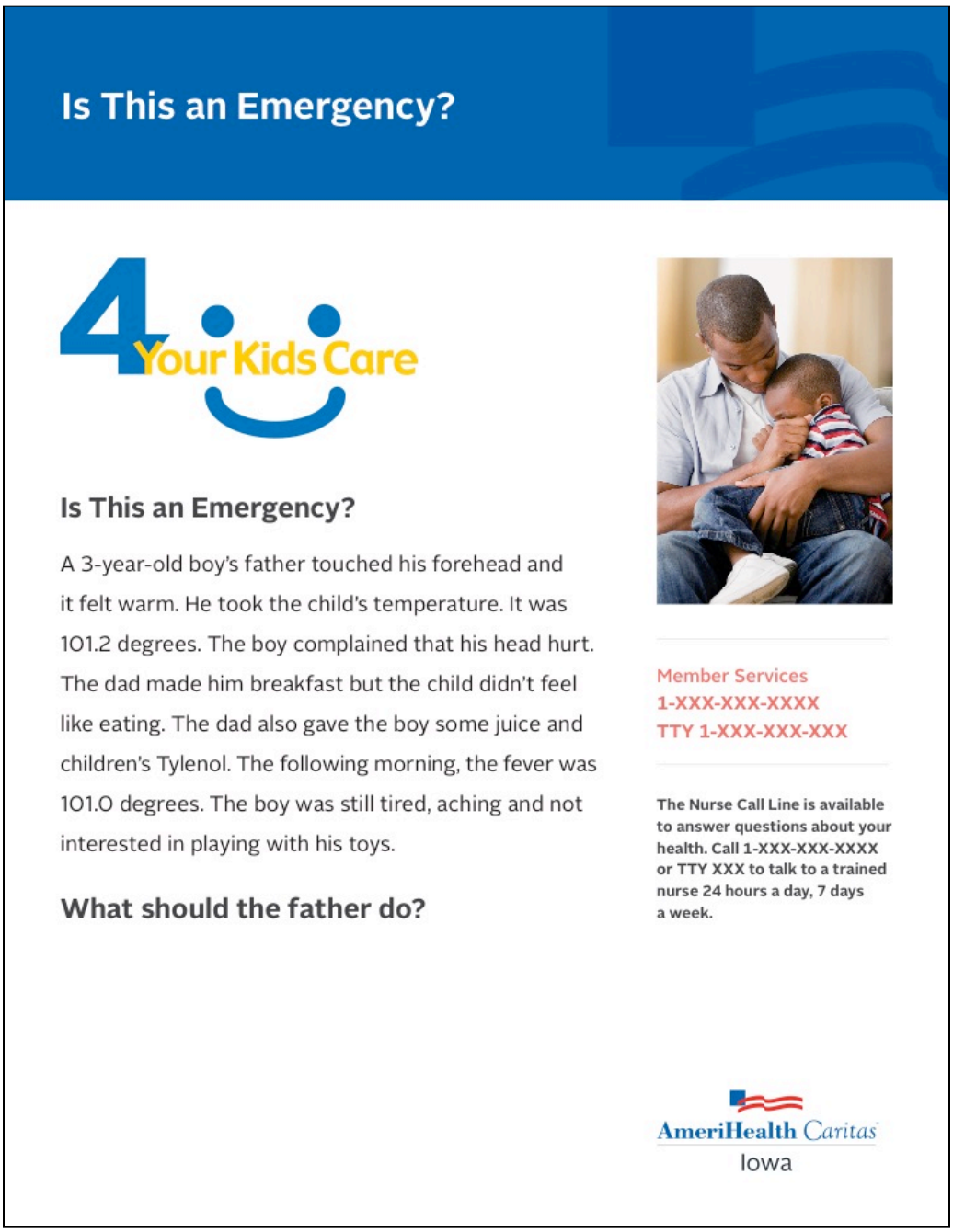

Exhibit 11.1-C: For Your Kids Care Education Example

Outcomes of our For Your Kids Care program:

To evaluate the effectiveness of this intervention, we conducted a one-year controlled pre/post matched-control analysis. Specifically, we investigated whether hands-on training and education of the parents/caregivers of pediatric Medicaid health plan members who have had prior non-emergent visits to the ER could reduce the subsequent incidences of these visits resulting in improved home-based care at significant cost savings. The study population analyzed consisted of 585 pediatric members with at least one ER claim for treating non-emergent conditions during the prior year whose parent/caregiver

participated in the classes. The matched control group consisted of 1,189 and 1,153 pediatric members with non-participating parents/caregivers in the pre- and post- periods, respectively. Statistical significance was set at P=0.05.

The average number of ER visits for non-urgent conditions decreased significantly in a six-month and 12-month period after members attended at least one class ($p<0.0001$). While the average number of ER visits for non-urgent conditions decreased significantly in a 12-month period for nonparticipants as well ($p=0.0097$), the mean reduction for study group participants was over three-fold greater than control group nonparticipants (-46.3 percent vs. -14.6 percent) over the same time period. Similarly, the amounts paid for ER claims for non-urgent visits during both six-month and 12-month periods decreased by over twice the amount for members after they attended at least one class than for non-participating members (-27.4 percent vs. -13.7 percent at six months; -37.8 percent vs. -17.4 percent at 12 months) over the same time period.

Additionally, a post-program survey of 705 program participants found that respondents were significantly less inclined to take a child with a fever or earache to the ER as a result of participating in the program.

Additional initiatives include:

- Automated discharge outreach surveys to support successful discharge plan implementation, ensure follow–up with the PCP and avoid a post-discharge trip to the ER.
- Targeted mailings for ER utilizers based on common non-emergent diagnoses, i.e., otitis media, or frequent usage of the ER.
- Increased visibility of urgent care centers and PCP offices that offer after-hour appointments.
- Asthma home assessments/educational visits in collaboration with the National Nursing Centers Consortium's Asthma Safe Kids program.
- New member assessment ER question — Has anyone in the household been to the ER four times or more in the last six months? Members who respond "yes" receive assessment and follow-up through the Rapid Response team.
- Monthly medication adherence reminders to members who are prescribed asthma, heart failure and diabetes medications.

We also offer all members access to our 24/7 Nurse Call Line. Daily information on member calls to the 24/7 Nurse Call Line, including the reason for the call and the advice given, is sent to the member's PCP and to the Rapid Response team. Care connectors in the Rapid Response team contact the member to assist the member to access care recommended during the call, including facilitating a PCP appointment. We will employ this approach in Iowa.

Across all of our Medicaid markets in 2014, between six percent and 15 percent of members who thought they needed to go to the ER or call 911 at the time they called the 24/7 Nurse Call Line were able to have their concerns addressed and healthcare needs met without an ER visit. Data for each of our affiliates is provided in the table below:

24/7 Nurse Call Line Diversion Summary 2014	
Plan	% of Triaged Members diverted from ER
AmeriHealth Caritas Pennsylvania	9%
AmeriHealth Caritas Northeast	10%
AmeriHealth Caritas District of Columbia	14.7%
AmeriHealth Caritas Louisiana	12%
Arbor Health Plan	5.9%
Blue Cross Complete of Michigan	6.8%
Keystone First	12%

Exhibit 11.1-D: 24/7 Nurse Call Line Diversion Summary (2014)

c. Identify aberrant provider practice patterns

In Iowa, we will utilize the robust analytic systems and resources of AmeriHealth Caritas to monitor service utilization at the member level and aggregate the results to look for patterns at the provider level. Individual member needs identified through this process are referred to the Integrated Healthcare Management (IHM) team program for outreach, assessment and coordination of additional supports.

Below we have included recent examples of aberrant provider practice patterns that we have identified and addressed:

Case study 1: Thoracic-Lumbar-Spinal Orthotic claim analysis

An analysis of claims for thoracic-lumbar-sacral orthotics (TLSO) identified an increase in TLSO claims over a three-year period, with a significant increase in claim submissions from one durable medical equipment (DME) company (Company X). The claim analysis also identified a clustering of claims paid just below $500, which was driving the total increase in TLSO claim volume.

The graph below shows that expenditures took off in 2013-2014 and that Company X accounted for all of the increase over the baseline. We found that Company X was exploiting a loophole in our authorization system that allowed all DME less than $500 to pay without prior authorization. We closed that loophole mid-2014, implementing prior authorization requirements for TLSO requests (many of which were found to be not medically necessary). The decline in medical costs for TLSOs in the second half of 2014 was entirely explained by a reduction in claims from the one identified company.

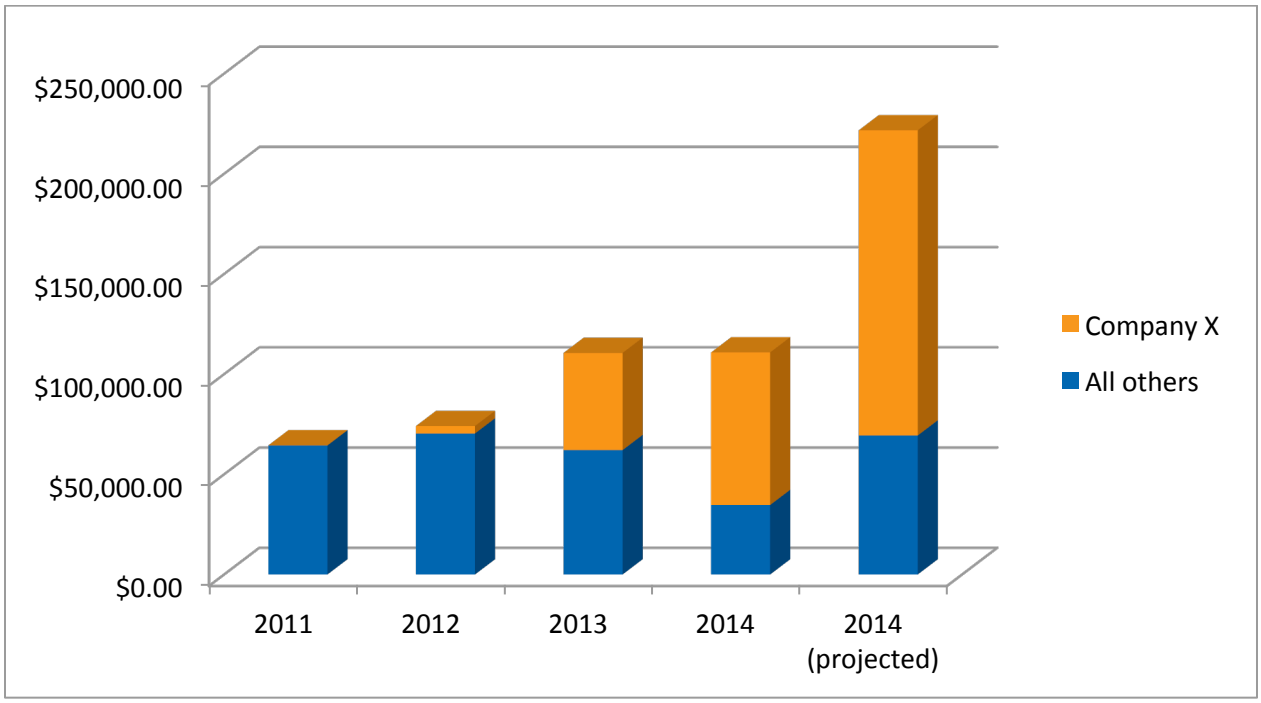

Exhibit 11.1-E: Total TSLO Claims

Case Study 2: Suboxone misuse

Analysis of controlled substance prescribing patterns in in our affiliate plan in Pennsylvania identified that many members were receiving prescriptions for Suboxone from out-of-network providers. Many of these providers were managing more than the 100-patient limit established by the Drug Enforcement Administration (DEA) for Suboxone prescribing. Moreover, site visits to high-volume Suboxone prescribers in the health plan network found that some were requiring cash payments — a practice that violates state and health plan rules. Project staff referred these cases to AmeriHealth Caritas' SIU and sent a fax blast to all Suboxone prescribers in the network to remind them of the health plan's prohibition on requiring cash payments.

To address the existing problems and create the infrastructure needed for evidence-based Medication-Assisted Treatment (MAT) with Suboxone, AmeriHealth Caritas decided to create a network of Suboxone prescribers who meet best-practice standards. AmeriHealth Caritas identified evidence-based standards for quality, documentation and member visits for Suboxone treatment that would be required to be contracted in a "preferred Suboxone network." Due to the fact that no formal credentialing process exists for Suboxone providers, we developed a provider office audit tool to track compliance with the identified standards for the initial and renewal certification to participate in the preferred Suboxone network. Some of the key items being integrated into the program are listed below:

- Confirming the provider's Controlled Substance Drug Enforcement Administration (XDEA) number and the absence of disciplinary action at the state and federal level.
- Evaluating the number of patients seen per hour to ensure appropriate attention is given to the member.
- Reviewing the provider's written policies and procedures for the induction and maintenance of patients on Suboxone therapy, including:

- The number of refills authorized on a Suboxone prescription.
- The procedures are in place to address reports of lost or stolen prescriptions.
- The presence of a comprehensive treatment agreement between the member and the provider.
- The process to refer members for a behavioral health evaluation and ensure that this visit occurs.

Currently, our Pennsylvania affiliate only has a single provider office in the Philadelphia market that has met these standards. As they continue to evaluate offices to join their preferred Suboxone Network they will evaluate member access to these providers. Once a critical mass of preferred Suboxone providers are contracted with the plan, they will remove the ability for Suboxone prescriptions from all other current Suboxone prescribers to be filled. At this point, any additional provider wishing to prescribe Suboxone for AmeriHealth Caritas members needs to complete a successful audit in accordance with AmeriHealth Caritas - Suboxone prescribing standards. Pharmacy point-of-service dispensing edits will only allow prescriptions from providers who meet the Suboxone prescribing standards, as evidenced by an onsite audit review, to be filled.

Providers that do not pass the audit will receive a deficiency notice that delineates the audit items the provider did not pass, provides education on the required standard and establishes a timeline for resolution. Those providers that are unable to achieve compliance will not be eligible to join the network. Providers that had previously been in the network and receive a deficiency notice on a repeat audit must become compliant within the timeframe allotted or they will automatically become ineligible to prescribe Suboxone for AmeriHealth Caritas members until such time as they are compliant and successfully complete a follow-up audit.

This evaluation process is currently underway and will continue throughout the remainder of 2015. Our Pennsylvania affiliate anticipates that by the first quarter of 2016, it will have evaluated a sufficient portion of contracted providers dispensing Suboxone to effectively close the network to only include providers were evaluated. This will also allow sufficient time for offices that received deficiency notices to become compliant.

To launch this new audit system, AmeriHealth Caritas will mail letters to all current and past Suboxone prescribers to explain that they must complete a quality audit and meet AmeriHealth Caritas standards to remain eligible to prescriber Suboxone to AmeriHealth Caritas members. The provider communication will detail the key components of the program listed in the bullets above as well as the expectations and timeline for correcting items deemed deficient. AmeriHealth Caritas' provider account executive will be available to the provider to discuss questions or concerns regarding the new credentialing requirements. In addition, the health plan's network medical director will be working in tandem with the account executive to enable a true peer-to-peer collaboration between the medical director and the prescribing physician. The ability to speak directly with a medical director has been received favorably by the provider network and provides a high-touch approach to the program. Finally, any prescriber who meets the best-practice standards will be included in the network, and AmeriHealth Caritas will conduct periodic audits to ensure compliance.

d. Monitor patient data related to length of stay and re-admissions related to hospitalizations and surgeries;

AmeriHealth Caritas of Iowa will use several methods to monitor length of stay and readmission data related to hospitalizations and surgeries. Through our robust data analytic capabilities, we produce

monthly reports on length of stay by type of admission and readmission rates. We also review the data by facility and diagnosis, to identify drivers of the results. Our UM team identifies previous admissions for current inpatient events, allowing us to proactively strengthen our discharge planning and follow-up activities for members with previous admissions. We also use Potentially Preventable Readmission (PPR) data in our predictive modeling algorithms, targeting members with PPRs for individual care management outreach and engagement.

Monthly key indicator reports and analysis

Our key indicator reports compare inpatient and outpatient services that were authorized and requested from the current period to the corresponding prior period, both on a monthly and year-to-date basis. In addition to serving as a forecaster of future claim activity, they allow the UM team to identify trends and variances from prior performance periods.

Report data includes separate results by admission type, breaking out specialty services such as neonatal intensive care unit (NICU) admissions, behavioral health admissions and maternity admissions. This allows the UM team to identify drivers for the identified trends. Length of stay data is also available by admission type. This is especially critical in markets where the majority of the contract arrangements pay a flat rate for the diagnosis-related group (DRG) or all patient refined diagnosis-related group (APDRG) for most admissions. Trend results by type of admission allow the UM team to focus on critical admission types, such as NICU, where the length of stay translates directly to the cost of the admission and is a proxy indicator of newborn health.

Diagnostic level reports use clinical classification software (CCS) to group admissions for like conditions to identify trends at the condition level. Drill-down data is used to identify specific diagnoses clusters driving the results, such as influenza, heat-related conditions and pregnancies. Using inpatient and outpatient authorization results, we monitor for unusual changes between specific periods of time.

Reduction of inappropriate inpatient admissions with lengths of stay two days or less

A statistical review of inpatient admissions with a length of stay less than or equal to two days was performed using 3M analytics and strict application of medical necessity criteria. A significant number of admissions were identified where the care provided could have been safely administered in the outpatient setting. Almost half of those cases presented with conditions that were ambulatory sensitive and potentially preventable admissions (PPAs), suggesting gaps in outpatient care. Specific PPAs identified in the data included:

A List of PPAs, Based on 3M APR DRGs		
• 053 – Seizure • 054 – Migraine & other headaches • 113 – Infections of upper respiratory tract • 137 – Major respiratory infections & inflammations • 138 – Bronchiolitis & RSV pneumonia • 139 – Other pneumonia • 140 – Chronic obstructive pulmonary disease • 141 – Asthma • 191 – Cardiac catheterization with circ disord exc ischemic heart disease	• 192 – Cardiac catheterization for ischemic heart disease • 194 – Heart failure • 198 – Angina pectoris & coronary atherosclerosis • 199 – Hypertension • 203 – Chest pain • 244 – Diverticulitis & diverticulosis • 249 – Non-bacterial gastroenteritis, nausea & vomiting • 251 – Abdominal pain • 383 – Cellulitis & other bacterial skin infections	• 420 – Diabetes • 422 – Hypovolemia & related electrolyte disorders • 463 – Kidney & urinary tract infections • 465 – Urinary stones & acquired upper urinary tract obstruction • 662 - Sickle cell • 722 – Fever

Exhibit 11.1-F: List of Potentially Preventable Admissions (PPAs)

To reduce this inappropriate inpatient utilization and improve outpatient management of these conditions, we implemented a mandatory medical director review of requests for inpatient admission for any of the above conditions. Requests for inpatient level of care for admissions not meeting medical necessity criteria were denied for and were approved for an observation level of care. This revision to our process has decreased the number of short inpatient stays for PPA-related diagnoses.

Readmission monitoring

We also monitor readmission data monthly and through real-time identification during the UM process. We track 30-day all - cause readmission rates by health plan and by facility. Separate analyses are performed to identify diagnoses related to readmissions. For example, in 2014, we identified that members with sickle cell disease accounted for a high-volume of readmissions for members in three of our affiliate health plans. Additional analysis identified many of these members were not receiving prescriptions for Hydroxyurea, an evidence-based treatment potentially helpful in preventing sickle cell pain crisis. We implemented educational outreach to the providers treating these members on the benefits of Hydroxyurea (and Penicillin in pediatric patients) for management of sickle cell disease. As part of the discussion, we shared the names of our members they were treating to whom the guidelines might apply.

We also implemented a member education campaign to reinforce healthy behaviors associated with sickle cell disease management, including hydration. As part of the campaign, members with sickle cell disease were sent a reusable water bottle and educational material encouraging them to talk with their doctor about available treatment options. A full analysis of the impact is in process; however, we have already seen an increase in the number of members receiving Hydroxyurea therapy.

Patient readmission data is also monitored real-time through our UM process. When an inpatient case is created (based on phone, Web portal, fax or admission/discharge/transfer data feed), the member's

history is reviewed to identify any previous admissions. Automated rules in the population health management system create alerts on member records when a new inpatient case is added to the system for a member with a previous discharge within 30 days. This functionality alerts the UM team to the need for enhanced discharge planning and follow-up.

Recognizing that readmission rates are highest in members with chronic conditions, we set a goal during 2014 to decrease the 30-day readmission rate for members with dominant chronic conditions or asthma. Dominant chronic conditions are conditions that are expected to result in continued health deterioration over time. To meet the goal, we strengthened all of our discharge planning processes and touch points. We also implemented targeted initiatives to address readmission drivers, including the behavioral health and sickle cell disease programs discussed above. Each health plan developed specific partnerships and initiatives, using data analysis, population health management system capabilities and core outreach common across all of our health plans to customize an approach specific for that health plan's members and providers. The result was an 11.5 percent decrease in 30-day readmissions for members with chronic conditions (including asthma).

e. Assure the appropriateness of inpatient care

AmeriHealth Caritas conducts medical necessity review of all inpatient hospitalizations, with the exceptions of maternity admissions for childbirth. We assess the appropriateness of inpatient care using clinical information from the facility related to the member's severity of illness, and the treatment planned and delivered. In addition, inpatient review provides information to facilitate the discharge plan and allows for peer consultation between the attending facility physician and the health plan's medical director as needed. The inpatient review process also identifies and facilitates transition to alternate levels of care when appropriate.

f. Ensure active participation of a utilization review committee

The Quality of Clinical Care Committee (QCCC), which reports in to the Quality Assessment Performance Improvement Committee (QAPIC), serves as the Utilization Review Committee for AmeriHealth Caritas Plans. AmeriHealth Caritas Iowa will actively solicit participating providers to serve as voting members on the committee. AmeriHealth Caritas Iowa's medical director will chair the QCCC.

AmeriHealth Caritas Iowa will take several steps to ensure the active participation of external physicians on our committee and to ensure that committee meetings serve as a forum for meaningful dialogue and activity. We are cognizant of the needs of the contracted community practitioners participating on the committee. We will schedule committee meetings outside of normal business hours to allow practitioners to more readily attend without disrupting their practice schedules. AmeriHealth Caritas holds meetings in the morning and evening, depending on the needs of the committee participants. As an example, QCCC meetings for AmeriHealth Caritas Iowa's affiliates in Pennsylvania are held at 6:00 p.m., while meetings for the South Carolina and Louisiana affiliates are held early in the morning at 7:30 a.m.

The QCCC participants are provided an agenda and meeting documents prior to the date of the meeting to allow them time to review and note any questions related to the information being presented. The QCCC chair solicits feedback on topics of discussion from the health plan QCCC participants and community providers.

As discussed in Section 10, we have already had introductory discussions with representatives of several potential sources of external members for the QCCC in QAPIC structure, including the QCCC. We will contact the following organizations to solicit representation for the QCCC:

- I4A (Iowa Association of Area Agencies on Aging).

- Iowa Association of Community Providers.
- Iowa Behavioral Health Association.
- Iowa Community Action Association.
- Iowa Health Care Association/Iowa Center for Assisted Living.
- Iowa Medical Society.
- Iowa Primary Care Association.
- Mercy Health Network.
- University of Iowa Health Alliance.

g. Evaluate efficiency and appropriateness of service delivery

Evaluating the efficiency and appropriateness of service delivery is a core tenet of the AmeriHealth Caritas Iowa UM program. Several programs and initiatives designed to evaluate efficiency and appropriateness with respect to medical necessity, practice patterns and under-/overutilization of services were discussed above. AmeriHealth Caritas Iowa will perform ongoing evaluation of the efficiency and appropriateness of services delivered by the UM team and program. In addition to a comprehensive annual evaluation of all program components, AmeriHealth Caritas Iowa will conduct daily, weekly and monthly evaluation of key service metrics.

Average speed of answer

UM supervisors monitor the wait times for calls in queue throughout the day, and adjust resource allocation to meet call demand. AmeriHealth Caritas Iowa will use the workforce monitoring platform used across all AmeriHealth Caritas health plans to understand call volume patterns, forecast demand and adjust resources accordingly. We monitor performance results for all UM teams against industry best-practice goals to ensure that the average call answer time is 30 seconds or below, and the average abandonment rate is less than five percent.

UM decision timeliness

Daily aging reports alert staff to cases that are approaching their decision due date. Weekly reports on the timeframe for decisions confirm that medical necessity determinations are made within the allotted timeframe for the type of decision. Monthly, each team reports their results, challenges and actions taken to address issues at a corporate-wide meeting. This meeting provides a forum for UM teams across the organization to share best practices and collaborate on solutions.

Case audits

In addition, routine case audits are performed to evaluate the appropriateness of steps taken in processing authorization requests, discharge planning and identification of additional needed actions. Audit elements address documentation of the receipt and process steps taken to make the determination and communicate the outcome. Additional elements focus on the application of criteria and the appropriateness of decisions made during the case. Several audit elements also evaluate connections the UM associate made for the member, including referrals to care management, identification of potential quality of care concerns, discharge planning and initiation of post-admission activities, where appropriate.

Audit results are shared with the individual handling the case and the team supervisor. Individuals with low scores (below 95 percent) are given additional training and coaching. For audit elements with negative findings for several team members, team-based refresher education is conducted.

Satisfaction results

Results of member, practitioner and provider satisfaction surveys are used to evaluate the efficiency and appropriateness of our UM program services. Consumer Assessment of Healthcare Providers and Systems (CAHPS) questions on Getting Care Quickly, along with feedback gathered during Stakeholder Advisory Committee meetings and analysis of provider dissatisfaction data, will provide insight into members' perceptions of UM program services. Annual practitioner and provider satisfaction surveys will be conducted using a third-party vendor to gather information on provider perceptions. This data will be combined with input from providers participating on our Stakeholder Advisory Council, QAPIC and QCCC, as well as feedback gathered during discussions between practicing providers and AmeriHealth Caritas Iowa medical directors and behavioral health medical directors.

Comprehensive annual evaluation

In addition, AmeriHealth Caritas will conduct a comprehensive evaluation of all aspects of its UM program annually to evaluate how well the program meets AmeriHealth Caritas Iowa goals for the delivery of efficient and effective services. The evaluation includes performance data for the entire program year. Results of the evaluation are used to develop recommendations for improvement, and propose goals and objectives for the following year.

h. Incorporate subcontractor's performance data

AmeriHealth Caritas Iowa retains full accountability and responsibility for the provision of services delivered to members through delegated relationships. As part of our robust program for delegation oversight, including pre-delegation assessment of capabilities, ongoing performance monitoring, and a comprehensive annual capability and performance audit, we evaluate and incorporate subcontractor performance data into our program operations and assessment.

Each delegate performing UM services will provide monthly performance data to the AmeriHealth Caritas Iowa QCCC and Quality of Service Committee (QSC). Performance standards for each contractor mirror the internal and external standards as AmeriHealth Caritas. All data presented is specific to performance related to AmeriHealth Caritas Iowa members, even for delegates who serve more than one AmeriHealth Caritas health plan. As part of the delegate oversight monitoring process, delegates who miss a performance goal are required to provide an explanation and planned action. If metric goals are missed for three months in a row, a formal action plan is required.

Prior to the delegation of any activity, a comprehensive pre-delegation assessment will be conducted to evaluate the delegation candidate's ability to perform the services in question according to AmeriHealth Caritas Iowa requirements. AmeriHealth Caritas Iowa reserves the right to investigate/audit the delegate at any time and to terminate the delegation agreement if the delegate's performance does not meet AmeriHealth Caritas' standards.

In addition, AmeriHealth Caritas Iowa will receive ongoing data feeds from delegates performing UM activities. These data feeds will take the form of authorization data in delegation arrangements where AmeriHealth Caritas Iowa retains the responsibility for claim payment. In arrangements where the delegate performs UM activities and claim payment functions, the data feeds will take the form of encounter files. These data sets are incorporated in our Facets® claim/eligibility system and/or data

warehouse, making them accessible to our Medical Economics teams. In this manner, subcontractor data is incorporated into analyses of utilization rates, over-/under-utilization, care gap identification and prior authorization requirements.

i. Facilitate program management and long-term quality

The UM program is one component of AmeriHealth Caritas Iowa's quality infrastructure and business processes that will allow AmeriHealth Caritas Iowa to achieve high-quality outcomes and service delivery. It is an integral part of the way AmeriHealth Caritas Iowa does business. In addition to providing an interface to the AmeriHealth Caritas Iowa Quality Assessment/Performance Improvement Program, the UM program employs systemic monitoring and evaluation of UM processes and services against objective criteria and tools. UM activities are monitored on the individual team and program level. Data used for quality monitoring includes, but is not limited to: average speed of answer, call volume, abandonment rate, IRR review outcomes and functional processes, including:

- Intake/triage.
- Prior authorization.
- Concurrent review.
- Discharge planning.
- Medical review.
- Provider appeals.
- Member appeals.
- Decision timeliness.

Action plans are developed to address identified variances. Performance results and action plan results are communicated to staff via individual sessions, team meetings and department communications. The results are also reported to the QAPIC.

j. Identify critical quality of care issues

AmeriHealth Caritas Iowa's UM program will serve as a window into the quality of care and services received by the individual member, and the population as a whole. Data collected through the performance of UM activities is used to identify critical quality of care issues, including:

- Potential quality of care issues on an individual member basis.
- Access issues and gaps in healthcare service availability.
- Aggregated data related to provider practice patterns.
- Areas for medical policy development and/or revision.
- Opportunities to improve processes to enhance provider and member experience with UM activities.

Potential quality of care issues will be investigated by the AmeriHealth Caritas Iowa Quality Management staff. The AmeriHealth Caritas Iowa clinical leadership team, led by the medical director, will take action to address access issues, gaps in healthcare service availability and medical policy changes. Data on provider practice patterns are reviewed by AmeriHealth Caritas Iowa leadership, with action taken under the direction of the AmeriHealth Caritas Iowa quality program. Opportunities to improve member and provider satisfaction are reviewed by the UM program medical leadership at least annually.

AmeriHealth Caritas Iowa staff report suspected fraud and abuse to the AmeriHealth Caritas Iowa compliance coordinator and the SIU for investigation and related actions. The AmeriHealth Caritas Iowa compliance coordinator will report the investigations, findings and actions taken, as appropriate, to the DHS Program Integrity Unit.

3. Provide a sample UM Work Plan

Purpose/Scope		Frequency	Responsible Party	Action Needed	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Comments
Program Documentation																	
1	UM program Description + annual review and approval. Goal: Annual review and update of the UM program consistent with achieving the health plan's mission of improving health outcomes.	Annual	UM Director or Designee	Review and Approve			X	Submit for DHS Approval									
2	UM work plan updates. Goal: Monitor and review planned UM activities; add additional activities as needed.	Quarterly	UM Director or Designee	Review and Approve	X			X			X			X			

Purpose/Scope		Frequency	Responsible Party	Action Needed	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Comments
3	UM program Evaluation. Goal: To provide an annual evaluation and report on the overall effectiveness of the UM activities and identify opportunities for updates and revisions to the program.	Annual	UM Director or Designee	Review and Approve				Submit for DHS Approval									
4	UM Work Plan (following year). Goal: Prepare UM work plan for following year.	Annual	UM Director or Designee	Review and Approve												X	Submit for DHS Approval
5	Review of UM Criteria and Revisions. Goal: Annual review and revision to UM medical necessity criteria/guidelines. Goal: Annual review and approval of the plan's criteria for medical necessity.	Annual	UM Director or Designee	Review and Approve				X									

Purpose/Scope		Frequency	Responsible Party	Action Needed	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Comments
Clinical Initiatives																	
6	ER Utilization Quality improvement initiative. Goal: Monitor ER rates and identify and review effectiveness of initiatives implemented to reduce unnecessary ER utilization.	Annual	UM Director or Designee	Review and Approve									X				
7	Consistency between UM criteria, disease management programs and clinical practice guidelines. Goal: Review UM criteria for consistency with disease management and clinical practice guidelines.	Annual	UM Director or Designee	Review and Approve							X						

Purpose/Scope		Frequency	Responsible Party	Action Needed	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Comments
Continuity of Care Reports																	
8	Inpatient discharge to outpatient setting. Goal: Review results and approve interventions for percentage of members with a PCP encounter within 30 days of being discharged to home from an acute inpatient admission.	Quarterly	UM Director or Designee	Review and Approve			X			X			X			X	
Utilization Reports																	
9	Inpatient/Outpatient Utilization. Goal: Review monthly inpatient and outpatient utilization reports; identify trends/opportunities.	Monthly	Medical Economics	Review and Approve	X	X	X	X	X	X	X	X	X	X	X	X	
10	Inpatient Readmissions. Goal: Review monthly inpatient readmission report; identify trends/opportunities.	Bi-Annual	Medical Economics	Review and Approve													

Purpose/Scope		Frequency	Responsible Party	Action Needed	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Comments
11	Preventive Care. Goal: Review reports comparing utilization of key clinical and preventive services to expected levels and external benchmarks; identify opportunities for improvement.	Quarterly	Medical Economics	Review and Approve		X			X			X			X		
12	Over-under-Utilization. Goal: Review results of routine and targeted investigations comparing utilization of key clinical services to expected levels and external benchmarks; identify opportunities for improvement.	Quarterly	Medical Economics	Review and Approve			X			X			X			X	
13	Provider Practice Patterns. Goal: Review outcome of provider level process and outcome data against expected levels and external benchmarks; identify opportunities for improvement.	Quarterly	Medical Economics	Review and Approve	X			X			X			X			

Purpose/Scope		Frequency	Responsible Party	Action Needed	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Comments
14	Drug Utilization Review. Goal: Assess drug utilization review (DUR) activity and outcomes.	Quarterly	Pharmacy	Review and Approve			X			X			X			X	
Appeals																	
15	Member Complaint and Grievances. Goal: Report member complaint and grievance timeliness, outcomes and data trends; implement initiatives in response to identified opportunities.	Semi-Annual	UM Appeals Manager	Review and Approve				X						X			
16	Member Appeals. Goal: Report member appeal timeliness, outcomes and data trends; implement initiatives in response to identified opportunities.	Quarterly	UM Appeals Manager	Review and Approve	X (4th Quarter prior year)			X (1st Quarter prior year)			X (2nd Quarter prior year)			X (3rd Quarter prior year)			

Exhibit 11.1-G: Sample UM Workplan

4. Describe if any UM functions will be delegated: If any functions will be delegated, describe proposed ongoing monitoring strategies of the delegated entity

AmeriHealth Caritas Iowa will delegate UM activity associated with medical necessity review of high-tech radiology services to National Imaging Associates (NIA). Under this arrangement, NIA will process prior authorization requests for computerized tomography (CT), computerized tomography angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission

tomography (PET) and nuclear cardiology services. AmeriHealth Caritas uses NIA services in a similar fashion in several of our other health plans.

As part of the process to implement NIA services for AmeriHealth Caritas Iowa, results of a comprehensive review of NIA policies, processes and performance will be reviewed by the AmeriHealth Caritas Iowa QAPIC as part of the process to approve delegation of medical necessity review for high-tech radiology services. The criteria used by NIA for medical necessity determinations will also be reviewed through AmeriHealth Caritas Iowa's quality process, including review and approval by practicing physicians on the QCCC.

Once implemented, AmeriHealth Caritas Iowa will review monthly performance data outlining NIA's compliance with AmeriHealth Caritas Iowa and NCQA processes. Performance data from NIA will be reviewed by the AmeriHealth Caritas Iowa QCCC and QSC. All data presented will be specific to NIA's performance related to AmeriHealth Caritas Iowa members. As part of the delegate oversight monitoring process, NIA will be required to provide an explanation and planned action when performance goals are missed. If NIA misses a performance goal for three months in a row a formal action plan is required. If performance deficiencies remain unresolved in accordance with the time frames set forth in the corrective action plan, AmeriHealth Caritas Iowa will exercise its right to withdraw delegation consistent with the terms of the delegation agreement with NIA.

AmeriHealth Caritas also reserves the right to investigate/audit NIA at any time. Complaints concerning service provided by NIA are reviewed and handled through the AmeriHealth Caritas Iowa Grievance System (for member complaints) and Provider Service team (for provider complaints). This provides a mechanism to track and trend the volume, topic and resolution of issues reported.

Annually, AmeriHealth Caritas Iowa will conduct a comprehensive review of NIA policies, processes and performance. We will audit prior authorization requests that resulted in an approval and requests that resulted in a denial to ensure that NIA continues to perform in accordance with AmeriHealth Caritas and NCQA standards. The results of the review are presented to the AmeriHealth Caritas QAPIC, who makes the determination whether to continue or terminate delegation.

5. Describe the process for developing and updating practice guidelines

Adherence to consistent evidence-based national standards has been demonstrated to improve the health of the population. Clinical practice guidelines are critical to setting the standards for delivering high-quality healthcare and reducing risk. They establish protocols for providing consistent evidence-based care to all members. Adopting best practices established by AmeriHealth Caritas in all of its markets, AmeriHealth Caritas Iowa will identify and adopt clinical practice guidelines based on clinical evidence or a consensus of healthcare professionals in a particular field.

In choosing clinical guidelines for adoption, AmeriHealth Caritas Iowa will focus on clinical areas that are important to the healthcare needs of its members, subject to variation in the delivery of service and where the use of evidence-based practice has been shown to improve health outcomes. We consider and select guidelines based on the following criteria:

- Incidence of the identified disease state in the target population.
- Ability of guideline adherence to improve the health state of the affected member.
- Current professional standards, supported by scientific evidence and research.
- Approval and support by relevant professional medical organizations.

With the participation of AmeriHealth Caritas Iowa's medical director, all new clinical guideline recommendations will be reviewed by the AmeriHealth Caritas National Clinical Policy Committee. Once approved by the enterprise committee, the clinical guideline recommendation will be submitted to AmeriHealth Caritas Iowa's QAPIC for review with suggestions for ways to increase adoption within the health plan's network. Recommended guidelines will also be reviewed by participating providers in the AmeriHealth Caritas Iowa network to identify additional considerations based on local practice patterns as well as ideas on ways to remove barriers to adoption in the market.

AmeriHealth Caritas reviews existing guidelines at a minimum of every two years and more frequently as new information becomes available. The guidelines in the table below will be presented to AmeriHealth Caritas Iowa's QAPIC for review, approval and discussion of ways to improve adherence to these evidence-based standards of care during its first committee meeting.

Guideline Topic	Guideline Source and Location
Asthma	• General Principles in the Management of Asthma. • http://mqic.org/pdf/mqic_general_principles_for_the_diagnosis_and_management_of_asthma_cpg.pdf. • GINA 2014. • http://www.ginasthma.org/local/uploads/files/GINA_Report_2014_Aug12.pdf. • The National Heart, Lung, and Blood Institute (NHLBI) Guidelines for the Diagnosis and Management of Asthma, 2007. • http://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines/full-report.
Attention Deficit Hyperactivity Disorder (ADHD)	• American Academy of Pediatrics Clinical Practice Guideline for Diagnosis, Evaluation and Treatment of ADHD in Children and Adolescents. • http://guideline.gov/content.aspx?id=36881&search=adhd. • CDC. • http://www.cdc.gov/ncbddd/adhd/diagnosis.html. • American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, 2013.
Cardiac Disease	• 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation. 2014; 129:S49-S73. • http://circ.ahajournals.org/content/129/25_Suppl_2/S49. • 2013 AHA/ACC Guideline on Lifestyle Management to Reduce Cardiovascular Risk: A Report of the American Heart Association/American College of Cardiology Task Force on Practice Guidelines. Circulation. 2014; 129:S76-S99. • http://circ.ahajournals.org/content/129/25_Suppl_2/S76.
Cholesterol Management	• 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults. • https://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437738.63853.7a .
COPD	• Global Strategy for Diagnosis, Management, and Prevention of COPD, 2014. • http://www.goldcopd.org/uploads/users/files/GOLD_Pocket_2014_Jun11.pdf . • American College of Physicians Guidelines on Diagnosis and Management of Chronic Obstructive Pulmonary Disease. • http://www.keystonefirstpa.com/pdf/provider/resources/cpg/copd-guideline.pdf.

Guideline Topic	Guideline Source and Location
Depression (Adult)	• Michigan Quality Improvement Consortium Guideline. • Primary Care Diagnosis and Management of Adults with Depression. • http://mqic.org/pdf/mqic_primary_care_diagnosis_and_management_of_adults_with_depression_cpg.pdfhttp://mqic.org/pdf/mqic_primary_care_diagnosis_and_management_of_adults_with_depression_cpg.pdf. • ICSI, Adult Depression in Primary Care Guideline, 2013 https://www.icsi.org/_asset/fnhdm3/Depr-Interactive0512b.pdf.
Diabetes	• Michigan Quality Improvement Consortium Guideline. • Management of Diabetes Mellitus. • http://mqic.org/pdf/mqic_management_of_diabetes_mellitus_cpg.pdf. • American Diabetes Association, 2014 http://care.diabetesjournals.org/content/37/Supplement_1/S14.full.pdf+html.
Hypertension	• Michigan Quality Improvement Consortium Guideline Medical Management of Adults with Hypertension. http://mqic.org/pdf/mqic_medical_management_of_adults_with_hypertension_cpg.pdf. • 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report from the Panel Members Appointed to the Eighth Joint National Committee (JNC 8). JAMA. 2014; 311(5): 507-520, doi:10.1001/jama.2013.284427.
Maternity: Routine Prenatal and Postpartum Care	• Michigan Quality Improvement Consortium Guideline Prenatal and Postnatal Care. • http://mqic.org/pdf/mqic_routine_prenatal_and_postnatal_care_cpg.pdf. • ICSI 2012 Health Care Guideline Routine Prenatal Care. https://www.icsi.org/_asset/13n9y4/Prenatal-Interactive0712.pdf.
Maternity: Primary Care Interventions to Promote Breastfeeding	• USPTF recommendations. • http://www.uspreventiveservicestaskforce.org/uspstf08/breastfeeding/brfeedsum.html. • .AAFP • http://www.aafp.org/afp/2004/0115/p354.html.
Obesity (Adult)	• Michigan Quality Improvement Consortium Guideline Management of Overweight and Obesity in the Adult. • http://mqic.org/pdf/mqic_management_of_overweight_and_obesity_in_the_adult_cpg.pdf. • NHBLI, Obesity. • http://www.nhlbi.nih.gov/guidelines/obesity/prctgd_c.pdf. • ICSI, Prevention and Management of Obesity for Adults, 2013. https://www.icsi.org/_asset/s935hy/Obesity-Interactive0411.pdf.
Obesity (Child)	• Michigan Quality Improvement Consortium Guideline Prevention and Identification of Childhood Overweight and Obesity. • http://mqic.org/pdf/mqic_prevention_and_identification_of_childhood_overweight_and_obesity_cpg.pdf. • CDC Childhood Overweight and Obesity Guidelines. • http://www.cdc.gov/obesity/childhood/index.html.

Guideline Topic	Guideline Source and Location
Sickle Cell Disease	• National Heart, Lung, and Blood Institute: Division of Blood Diseases and Resources: Evidence-Based Management of Sickle Cell Disease: Expert Panel Report, 2014. • http://www.nhlbi.nih.gov/health-pro/guidelines/sickle-cell-disease-guidelines/. • http://jama.jamanetwork.com/article.aspx?articleid=1902235.

Exhibit 11.1-H: Example Quality Guidelines and Sources

AmeriHealth Caritas Iowa will adhere to state and NCQA guidance on practice guideline dissemination. AmeriHealth Caritas Iowa will notify providers of new or changed practice guidelines via fax blasts, our provider email service ("Network News"), and hard copy mail. Fax blasts are used to notify providers that clinical practice guidelines are posted on the AmeriHealth Caritas Iowa website and can be accessed by providers, members and other interested parties. Active practice guidelines will be stored and retained on AmeriHealth Caritas Iowa's website for at least two years. Providers can request a hard copy of the guidelines by contacting their Provider Network account executive.

6. Describe how your UM program will integrate with other functional units as appropriate and support the Quality Management and Improvement Program

The American healthcare system is undergoing unprecedented change with the goal of delivering better care through an enhanced customer experience, better quality and lower cost. AmeriHealth Caritas Iowa promotes teamwork among departments with different yet complementary knowledge and skills. Our UM team works closely with care management), Rapid Response team, medical directors, provider network management, quality management, pharmacy, behavioral health and operations to develop internal and external relationships. Our collaboration achieves better outcomes and supports, improves provider engagement and satisfaction and integrates utilization management, care management, provider network management, quality management and medical director’s efforts to close gaps in needed services for members touched through UM activity. This integrated approach will incorporate the goals and strategies driving AmeriHealth Caritas Iowa’s QAPI program and efforts.

Examples of AmeriHealth Caritas Iowa UM program activities that are integrated with other functional units in support of quality management and improvement goals include:

- **Discharge planning:** UM associates coordinate needed services for members transitioning from the inpatient setting to home, including arranging for in-home follow-up from care coordinators in the Rapid Response team or AmeriHealth Caritas Iowa’s COS team. Our seamless process to task members of these teams to perform critical post-discharge follow-up, including ensuring needed medications are available, facilitating a post-discharge physician appointment and reinforcing warning signs that indicate the need to contact a physician, promotes access to appropriate care and reduction of preventable care events which are key tenets of our QAPI program.
- **Care gap dissemination:** Through AmeriHealth Caritas Iowa’s robust technology infrastructure, providers authorized to deliver in-home services for members, including skilled nursing and therapy services, will have access to information on recommended services the member has not received. These care gaps will be identified on the Member Clinical Summary accessible to the home health team through the AmeriHealth Caritas Iowa Provider Portal. This capability allows providers receiving authorizations for in-home care to develop a comprehensive approach to the member’s needs and supports QAPI program goals related to the use of evidence-based practice guidelines.

- **Care management member identification:** Several activities and systems within the UM program facilitate the identification of members in need of additional care management support. All UM associates are trained in the internal process to create an activity in the population health management system to initiate a care management assessment. In addition, case audits, performed for all UM associates, review and score appropriate referral for care management as an audit element. This referral process is one mechanism AmeriHealth Caritas will use to address unmet member needs.
- **Out of network requests:** AmeriHealth Caritas Iowa medical director and Provider Network Management team will review requests to have covered services delivered by providers that are not part of the AmeriHealth Caritas Iowa network to identify whether there is an available provider in the network that can deliver the requested service. Cases where an appropriate provider does not exist are reviewed to see whether additional network recruitment and contracting efforts are needed. This integration will help AmeriHealth Caritas Iowa provide appropriate access to care for its members.

7. Describe how the UM program will encourage health literacy and informed healthcare decision-making

Several AmeriHealth Caritas Iowa core practices, designed to encourage health literacy and informed healthcare decision making, are utilized in the UM program. These include a foundation of cultural competency, use of plain language in written and oral communication, use of interpretation and translation services for members with limited English proficiency and use of alternate communication modalities for members with vision and hearing disabilities. In addition, AmeriHealth Caritas Iowa encourages open discussion between the treating provider and member to review all available treatment options, and will disseminate information from trusted sources to aid members in making informed healthcare decisions. Member materials used to reinforce healthcare services related to transitions of care provide clear, easy to read guidance on recommended next steps.

Cultural consideration

AmeriHealth Caritas Iowa fully recognizes the importance of addressing the needs of members in a culturally competent and linguistically appropriate manner. This is an integral part of our overarching strategy to promote health equity, deliver person-centered care and reduce health disparities. AmeriHealth Caritas Iowa will continue the successful and consistent practices used by AmeriHealth Caritas to ensure that services are provided to all members in a manner that values, affirms and respects their worth, in addition to protecting and preserving their dignity.

All AmeriHealth Caritas Iowa associates are trained upon hire and annually thereafter in Culturally and Linguistically Appropriate Services (CLAS) standards and health equity. This helps reinforce our philosophy throughout the organization so that all associates are empowered to help members receive equal access to care. We also provide this training to our physician and dental communities as well.

Use of plain language

Whenever possible, our UM associates use non-clinical terms when discussing requested healthcare services with members. We understand the relationship between low health literacy and poor health outcomes, and the associated impact on healthcare costs. Members with low health literacy, specifically those who cannot read, understand or act on health information and instructions, face multiple health risks. Confusion about, or lack of, healthcare information may result in poor control of chronic illnesses such as diabetes, more hospitalizations and longer lengths of stay and improperly taken medications.

All of our written materials adhere to literacy and plain - language guidelines. We follow a documented process to produce all communication materials in accordance with cultural competency and literacy requirements. Materials are available in alternative formats to members with specialized needs. Strategies that help us accomplish this include:

- Using simple vocabulary to convey information and minimizing the use of medical jargon.
- Using language that is at or below a sixth grade reading level.
- Choosing appropriate design formats that maximize white space and include easy-to-read fonts and layouts.
- Translating materials into Spanish, German, French and other alternate languages.
- Making materials available in alternate formats (large print, Braille, compact disc and audiotape).
- Testing our materials with member focus groups.
- Using diverse graphics on materials to engage members.

Members with disabilities

For members who are unable to communicate their needs through spoken words, we use a variety of techniques to ensure they have information needed to access the UM process. For members who are hearing-impaired, sign-language interpreters or TTYD systems can be used to conduct the conversation.

Members with limited English proficiency

For members who are not proficient in English, interpreters or bi-lingual UM staff are used to communicate UM decisions. For language needs that are not common in the population, AmeriHealth Caritas Iowa will employ the services of Language Services Associates (LSA) to provide real-time language interpretation. LSA is able to provide interpretation services in over 200 languages.

In addition, AmeriHealth Caritas Iowa will translate written materials, including UM Notice of Action into needed languages. We will contract with a translation service capable of translating materials into over 100 languages.

Encouraging informed decision making

AmeriHealth Caritas Iowa includes language in provider agreements outlining our position to encourage a comprehensive and frank discussion of treatment options with members. We will not penalize a practitioner or provider for advocating on behalf of a member, including in the context of a UM appeal or other dispute over appropriate medical care. Specifically, the below contract language exemplifies our position and supports informed decision making:

- **Provider Discrimination Prohibited.** AmeriHealth Caritas Iowa may not, with respect to provider compensation or indemnification under this Agreement, discriminate against provider to the extent that the provider is acting within the scope of his, her or its license or certification under applicable State law, solely on the basis of that license or certification. Without limiting the foregoing, AmeriHealth Caritas Iowa shall not discriminate against provider for serving high-risk populations or specializing in conditions that require costly treatment. Nothing herein shall be construed to: (i) require AmeriHealth Caritas Iowa to contract with provider if not necessary to meet the needs of members; (ii) preclude AmeriHealth Caritas Iowa from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or (iii) preclude AmeriHealth

Caritas Iowa from establishing measures that are designed to maintain quality of services and control costs and are consistent with AmeriHealth Caritas Iowa's responsibilities to members 42 CFR §438.12.

- **Provider-Member Communications.** Nothing in this Agreement shall be construed to prohibit, restrict or impede a provider's ability to freely and openly discuss with members, within the provider's lawful scope of practice, all available treatment options and any information the member may need in order to decide among all relevant treatment options, including but not limited to the risks, benefits and consequences of treatment or non-treatment, regardless of whether the services may be considered Covered Services in accordance with this Agreement. Further, nothing in this Agreement shall be construed to prohibit, restrict or impede provider from discussing Medically Necessary care and advising or advocating appropriate medical care with or on behalf of a member, including: information regarding the nature of treatment options, risks of treatment, alternative treatments or the availability of alternative therapies, consultation or tests that may be self-administered and the member's right to participate in decisions regarding his or her care, including the right to refuse treatment and to express preferences about future treatment decisions 42 CFR §438.102(a).

We provide members with access to actionable information on healthcare outcomes for physicians, hospitals and other providers from trusted sources to enable members to make informed healthcare decisions. The primary method of access to this data will be through the Member Portal. Data sources we plan to provide include:

- **NCQA - PCMH:** http://recognition.ncqa.org/PSearchResults.aspx?state=IA&rp=6
- **NCQA - recognized physicians in diabetes:** http://recognition.ncqa.org/PSearchResults.aspx?state=IA&rp=3 and in heart disease and stroke: http://recognition.ncqa.org/PSearchResults.aspx?state=IA&rp=2
- **CMS Physician Compare:** http://www.medicare.gov/physiciancompare/
- **CMS Hospital Compare:** http://www.medicare.gov/hospitalcompare/results.html#dist=25&state=IA&lat=0&lng=0

Additionally, information on board certification status is contained in our online Provider Directory.

These credible sources of information have demonstrated impacts upon selection of physicians and hospitals which may translate into better member outcomes and experiences of care.

Finally, member materials used to educate members at key transition points, such as returning home from after an inpatient stay, are developed using the health literacy and plain language processes described above. These materials assist members to understand the importance of receiving timely follow-up care, adhering to medication schedules and watching for signs and symptoms that should be reported to their physician.

8. Describe strategies to monitor member access to preventive care and strategies to increase member compliance with preventive care standards. Describe how you will identify and address barriers which may inhibit a member's ability to obtain preventive care

AmeriHealth Caritas Iowa will employ the successful strategies and initiatives used by its affiliate health plans to monitor member access to preventive care, increase member compliance and resolve member barriers members to preventive care. Our approach will focus on three core components of our IHM model: a robust population health management infrastructure to identify and disseminate gaps in care,

alignment of member and provider incentives, and proactive outreach and screening for barriers to receiving recommended care.

Preventive care gaps

Care gaps occur when members do not receive (or there is no documentation that they received) services recommended by evidence-based clinical practice guidelines. On a monthly basis, AmeriHealth Caritas Iowa will analyze available data sets, including claims information, immunization registries and electronic medical record data, against evidence-based algorithms for preventive health services to identify gaps in care. Care gap algorithms exist for a full range of preventive services, including child and adolescent wellness measures, immunizations and cancer screenings.

Preventive Care Gaps	
• Well Visits	• Well-child visit (all ages). • Adolescent well-visit. • Adult well-visit.
• Early Prevention Screening Diagnosis Treatment (EPSDT)	• Developmental screening. • Hearing screening. • Lead screening. • Vision screening.
• Immunizations	• Chicken Pox vaccination. • Diphtheria, Tetanus and Pertussis Vaccination. • Haemophilus Influenza Type B Vaccination. • Hepatitis B Vaccination. • Measles, Mumps and Rubella Vaccination. • Pneumococcal Conjugate Vaccination.
• Cancer Screening	• Breast cancer screening. • Cervical cancer screening. • Colorectal cancer screening.
• Other Services	• Annual dental visit. • Chlamydia screening.

Exhibit 11.1-I: Preventive Care Gaps

Care gap alerts are integrated into our population health management platform, visible to associates performing UM, quality management, care management and member service activities. The associates see an alert in the member's record when the member's ID number is entered in the system. This will allow AmeriHealth Caritas Iowa staff to proactively address the need for recommended preventive health services while the member is on the phone. Through one approach of making every member contact count, AmeriHealth Caritas Iowa Member Service and Care Management staff review the recommended preventive health service with the member, assist the member to schedule an appointment and screen for any barriers to obtaining the service. Our associates will also check the preventive healthcare needs for other family members through the family link functionality in our population health management system. This allows an AmeriHealth Caritas representative talking with a mother of four children to review and assist with scheduling the services needed for all four of the children during the same call.

Providers will receive preventive healthcare gap information through our Provider Portal, both as a member-specific alert during an eligibility check and through on-demand reports containing preventive health needs for all of their assigned members. When the member's ID number is entered in the portal, a pop-up alert appears notifying the provider that a care gap exists. When the provider clicks on the alert, a member level report appears, identifying missing and overdue services, care gaps and up-to-date services. The provider can also access a report of all preventive healthcare gaps for assigned members, either as a printable document or as a CSV file that can be incorporated into other systems.

Preventive healthcare gap information is also present on the Member Clinical Summary (MCS), available to all providers through the member eligibility screen in the Provider Portal and to members through the secure Member Portal. The MCS can be viewed online, printed for inclusion in a paper medical record or downloaded as a continuity of care document (CCD) for integration into an electronic medical record. Members can print the MCS to bring with them to the physician's office. An expanded MCS is delivered for children, including information on all EPSDT wellness visits, screening and immunizations received.

Members using the AmeriHealth Caritas Iowa mobile application will receive information on recommended preventive health services through screens in the application and as text reminders. The text reminder will provide a call to action, offering the member the ability to touch the screen and connect to the AmeriHealth Caritas Contact Center of Excellence for assistance in scheduling.

Aligning member and provider incentives

To drive members and providers to take action to address identified gaps in preventive health services, AmeriHealth Caritas Iowa will include key preventive healthcare services in the respective member and provider incentive programs. To drive member behavior, AmeriHealth Caritas Iowa will implement the CARE Card program using a reloadable card to deliver cash incentives to members who receive recommended preventive health services. Metrics base on preventive health services will also be included in the Quality Enhancement (pay for performance) program for PCPs.

Proactive outreach and barrier identification

To facilitate the delivery of timely preventive health services to members, AmeriHealth Caritas will implement ongoing phone and text message outreach programs designed to alert members to needed preventive care services and facilitate a one-touch connection to obtain assistance. Our text reminder program will leverage feedback loops that allow us to validate the response to each message delivered. Through these mechanisms we continually refine the language used to drive desired member behavior.

During outreach calls, we will review recommended services and offer real-time assistance, through a three-way call, to facilitate scheduling an appointment. We will proactively ask the member about common barriers that may arise, including child care and transportation. As needed, we will assist the member to explore options for child care and make arrangements with available transportation services. We will also reinforce the importance of keeping scheduled appointments and contacting the office if something does arise that impacts the member's ability to attend the appointment. For members who are overdue for recommended services, we will set a date-reminder on the member's record to trigger a call to the member the day before the scheduled visit to remind the member of the visit and reassess for any potential barriers.

Innovations in removing barriers to health care

AmeriHealth Caritas believes that every individual has the right to quality healthcare and services and to benefit from healthcare innovation and technology, regardless of socio-economic status. We proactively

seek out partnerships with like-minded organizations that share our passion for equipping individuals with the information they need to make informed decisions about their overall health and wellness, and that share our passion for caring for the whole person through a fully integrated model of care and services.

An example of how AmeriHealth Caritas partners with like-minded and innovative organizations to make quality healthcare and services accessible and affordable to every person, is our soon to be announced strategic partnership with Theranos. Aided by cutting-edge Theranos technology, AmeriHealth Caritas is taking an historic step in transforming how Medicaid members are able to engage in timely, meaningful discussions with their healthcare Provider about their overall health and wellness and comprehensive care plans.

Theranos is a CLIA-certified laboratory that offers services for a complete range of tests from common blood screening panels to specialized testing across all specimen types. Theranos' revolutionary laboratory service platform uses dramatically smaller samples than traditional labs, with samples collected from both capillary draws and traditional methods. Results are returned much faster than industry averages, with the overwhelming majority of results reported within 24 hours of sample collection. The process for utilizing Theranos services is consistent with what Providers and patients are accustomed to today, with improvements to enhance the ease of each step.

AmeriHealth Caritas recognizes that laboratory test results drive many healthcare decisions, but the process in obtaining the results can be scary, intimidating, inconvenient and expensive. It is estimated that between 40-60 percent of laboratory tests are not completed, which means that individuals and their healthcare providers likely don't have all the right information at the right time to make important healthcare decisions or develop comprehensive care plans. Our new strategic partnership with Theranos provides an opportunity for us to quickly, and more actively, engage all new members in Iowa in their overall health and wellness.

We believe that we are the first Medicaid managed care organization in the nation to bring this innovative, evidence-based and customizable solution to our members and providers. We expect to publicly announce our strategic partnership with Theranos shortly and intend to bring this innovative solution to all of the markets and Medicaid Members we serve.

9. Describe your UM Committee, including proposed committee composition and tasks

The QCCC will provide direct monitoring, oversight, and direction for the UM program, and reports into the QAPIC, AmeriHealth Caritas Iowa medical director and, ultimately, the AmeriHealth Caritas Iowa board of directors. The chairperson of the QCCC is an AmeriHealth Caritas Iowa medical director. QCCC members will include participating AmeriHealth Caritas Iowa providers and a cross-section of leadership from AmeriHealth Caritas Iowa departments.

Over the past few months, we have initiated conversations with providers in Iowa to introduce ourselves and our programs. We have identified the following organizations we will recruit from for our quality committees:

- I4A (Iowa Area Agency on Aging).
- Iowa Association of Community Providers.
- Iowa Behavioral Health Association.
- Iowa Community Action Association.
- Iowa Health Care Association/Iowa Center for Assisted Living.

- Iowa Medical Society.
- Iowa Primary Care Association.
- Mercy Health Network.
- University of Iowa Health Alliance.

The QCCC is responsible for the following:

- Reviewing and approving clinical and preventive practice guidelines.
- Adoption of utilization review criteria (new and revised).
- Monitoring and evaluating utilization of health services (including overutilization, underutilization and outliers) and the effectiveness of UM activities.
- Monitoring the medical appropriateness and necessity of healthcare services provided to members.
- Reviewing, approving and ensuring conformance with NCQA and industry standards of policies and procedures, including the method, timelines and individuals responsible for each task, related to the UM process and making changes, as needed.
- Monitoring providers' requests for delivery of healthcare services to members.
- Monitoring and evaluating performance related to appeal processing and service indicators.
- Reviewing results of program clinical outcome collection, clinical practice guideline adherence, medical record review outcomes, and utilization results to identify opportunities for improvement and oversee related improvement plans.
- Monitoring and evaluating consistent application of medical necessity criteria, and overseeing related improvement plans.
- Reviewing the effectiveness of the UM program and processes, and making changes as needed.
- Reviewing results of member and provider satisfaction surveys and appeal data to identify opportunities for improvement.
- Monitoring the process to have an AmeriHealth Caritas Iowa provider or medical director available at all times to respond to ER providers within one hour.
- Reviewing and approving the UM program description and UM program evaluation.
- Monitoring performance of program delegates and vendors, and recommending interventions as appropriate.

The QCCC review set results of overutilization and underutilization monitoring, prior authorization activity, decision timeliness, IRR and medical necessity appeal determinations to identify opportunities for improvement in program operations. Decisions to remove or institute authorization requirements or revise UM policies are made by the QCCC. The inclusion of participating providers as voting members in the QCCC ensures that policies and decisions reflect local practice patterns and provider needs.

10. Describe any benefits which are proposed to require PCP referral and what services would be available on a self-referral process

AmeriHealth Caritas Iowa does not propose to require the member to obtain a PCP referral as a precursor for accessing any covered services. AmeriHealth Caritas Iowa will actively encourage members to form a

close relationship with a PCP for coordination of care and holistic management of their needs. We provide PCPs with several tools to track the care a member is accessing, including the Member Clinical Summary (MCS), which lists the names, specialties, visit dates and visit reason for all specialist encounters. Additionally, the MCS identifies all prescriptions the member is receiving, giving the PCP a comprehensive overview of medications prescribed by other treating providers. We also require specialists to provide visit summaries to the PCP, outlining the specialist's findings and treatment plan. In our experience, these mechanisms provide more value to achieving a coordinated approach to healthcare delivery than a PCP referral program.

At AmeriHealth Caritas Iowa, our goal is to reduce the barriers to appropriate and necessary care while improving the healthcare experience for our members. For that reason we do not propose any PCP referral requirement.

11.2 Prior Authorization

1. Describe policies and procedures for processing authorization requests including when consultation with the requesting provider will be utilized

AmeriHealth Caritas Iowa's policies and procedures for processing authorization requests meet NCQA standards and 42 CFR 438.210(d) requirements and related rules and regulations. AmeriHealth Caritas Iowa will not employ, and will not permit any of our providers or others acting on our behalf to employ, utilization control guidelines or other quantitative coverage limits that are not based on an individualized determination of medical necessity based upon the needs and medical history of the member.

Processing prior authorization requests

Requests for prior authorization can be submitted by phone, fax, mail or through the AmeriHealth Caritas Iowa Provider Portal. Prior authorization requests may be submitted by the practitioner/provider ordering the service or performing the service or by the member. Information gathered for use in a prior authorization determination includes some or all of the following:

- Clinical history.
- History of present illness.
- Presenting symptoms.
- Prior treatment outcomes.
- Current clinical status.
- Plan of care.
- Prior utilization, including inpatient and ER history.
- Current treatment.

Prior authorization is performed by UM staff who are supervised by a registered nurse or licensed behavioral health clinician, and supported by Iowa-licensed physicians including psychiatrists and psychologists. Prior authorization decisions are based on the clinical indications in the member's individual situation with guidance from AmeriHealth Caritas Iowa medical necessity/psychosocial necessity criteria (described in detail in section 11.2.1, below). For the purposes of this section, medical necessity criteria

and psychosocial necessity criteria will be referred to as "medical necessity criteria." UM staff can approve requested services when UM medical necessity criteria have been met.

Any decision to deny, alter or approve coverage for an admission, service, procedure or extension of stay in an amount, duration or scope that is less than requested will be made by an AmeriHealth Caritas Iowa medical director, behavioral health medical director or physician designee with appropriate clinical expertise in treating the member's condition or disease. In the case of long-term care services, a long-term care professional who has appropriate expertise in providing long-term care services will be responsible for the decision. AmeriHealth Caritas Iowa will make these decisions only after evaluating the individual clinical history and health needs of the member, characteristics of the local delivery system and, as needed, consultation with the treating physician or provider. For requests for covered psychosocial services, such decisions will also include the impact of previous treatment and service interventions, services being provided concurrently by other delivery systems, the potential for services and supports to allow the member to maintain functioning improvement attained through previous treatment, unique circumstances which may impact the accessibility or appropriateness of particular services for the individual member, and the member's choice of provider or proffered treatment location.

Tammy is a 16-year-old with a history of childhood obesity (500 lbs.), sleep apnea and clinical depression secondary to her obesity. She is the oldest of three children residing with her mother with no active involvement from her father. The mother has a history of substance abuse and was not very supportive in previous plans of care.

Tammy was hospitalized three times in the previous year for sleep apnea complicated by her obesity. During her multiple hospitalizations, Tammy increasingly demonstrated signs of depression and suicidal thoughts. She was identified for care management. A care manager at our affiliated Pennsylvania health plan began working with the mother, PCP and behavioral health provider.

Interdisciplinary meetings with the behavioral health provider revealed that Tammy had tried and failed multiple weight loss initiatives over the past three years, contributing to her depression. As a result of the multidisciplinary meetings between the medical and behavioral health providers, the team planned to send Tammy to a highly specialized out-of-network facility that would concentrate on losing weight, monitoring and treating sleep apnea and providing psychological interventions for her depression.

Tammy is now 17 years old. She spent 14 months in the facility, losing over 250 pounds and stabilizing her sleep apnea. She is now attending ongoing outpatient treatment for weight management and depression. Tammy returned to school in a traditional setting and has not had any further hospitalizations for sleep apnea or depression.

At the request of the AmeriHealth Caritas Iowa medical director or behavioral health medical director, board-certified physicians from an appropriate specialty may participate in the decision. However, the AmeriHealth Caritas Iowa medical director will make the final decision. AmeriHealth Caritas Iowa will maintain a documented process to request board certified consultant involvement and include the recommendations in the review process.

Consultation with the requesting provider

Consultation with the requesting provider will be used in cases where the information available to support the medical necessity determination does not provide a clear picture of the member's clinical situation,

and needs or the requested treatment does not appear to match the member's needs. In these situations, an AmeriHealth Caritas Iowa medical director/behavioral health medical director will contact the requesting provider to review the information received and planned treatment. This interaction provides for a complete view of all of the member's medical and psychosocial needs related to the requested service.

Additionally, the notification process used to inform the member and requesting provider of a determination to deny authorization for a requested service, or to authorize the service in an amount, duration or scope that is less than requested, includes information on the ability of the requesting provider to discuss the determination with the AmeriHealth Caritas Iowa medical director/behavioral health medical director who made the decision. This process provides another mechanism to ensure that a full picture of the member's needs is reviewed as part of the authorization process. This discussion is offered in addition to the ability for either the member or provider acting on behalf of the member to file a formal appeal and does not take the place of any of the appeal levels and processes available to the member.

Prior authorization timeframes

Requests for prior authorization are completed as expeditiously as required by the member's health condition, and will not exceed the timeframes outlined below:

Review Type	Timeframe	Extension Timeframe
Pre-service standard (Non-urgent)	Seven calendar days from the date the request was received.	14 calendar days if requested by member or provider; or if AmeriHealth Caritas Iowa justifies that it is in the best interest of the member.
Pre-service expedited (Urgent)	As expeditiously as the member's health condition requires and no later than three business days after receipt of the request for service.	14 calendar days if requested by member or provider; or if AmeriHealth Caritas Iowa justifies that it is in the best interest of the member.
Post- service	30 calendar days from receipt of the request for service.	N/A

Exhibit 11.2-A: Prior Authorization Timeframes

Documenting prior authorization requests and determinations

AmeriHealth Caritas Iowa UM staff will document all prior authorization requests in our population health management system. Documentation will include the case number, requestor name, date, time and submission method associated with receipt of the request; the substance of the request, including an electronic copy of any faxed or mailed documents; the steps taken to review the request; the determination made, including the time, date, name and title of the person making the determination and rationale for the decision; and the time, date and name of the person notified of the determination. All notes will contain the name of the person making the entry, and for licensed staff, the appropriate suffix (e.g., RN, MD, PhD, RPh). For prior authorization requests that result in a denial or approval of a lesser amount or scope of service, documentation will also include a synopsis of the member's illness or condition, associated diagnoses, the treatment plan and the clinical guidelines and/or rationale used to make the determination.

Monitoring prior authorization processes

Daily aging reports alert staff to cases that are approaching their decision due date. Weekly reports on the timeframe for decisions confirm that medical necessity determinations are made within the allotted timeframe for the type of decision. Monthly, each team reports their results, challenges and actions taken to address issues at an enterprise-wide meeting. This meeting provides a forum for UM teams across the organization to share best practices and collaborate on solutions.

In addition, routine case audits are performed to evaluate the appropriateness of steps taken to process authorization requests. Audit elements address documentation of the receipt, and process steps taken to make the determination and communicate the outcome. Additional elements focus on the application of criteria and the appropriateness of decisions made during the case. Audit results are shared with the individual handling the case as well as the team supervisor. Individuals with low scores (below 95 percent) are given additional training and coaching. For audit elements with negative findings for several team members, team-based refresher education is conducted.

Continuous improvement

AmeriHealth Caritas is implementing new efforts to improve efficiency and effectiveness of the prior authorization process that will be in effect by January 1st, 2016. The goals of this effort are to:

1. Reduce the number of current procedural terminology (CPT) codes requiring authorization, which will:
    A. Reduce the number of calls and faxes received.
    B. Allow for redeployment of UM associates to perform other roles that may increase our “touch rate” with members.
    C. Reduce the administrative burden associated with prior authorization for providers.
2. Perform a process improvement analysis to see where we may be able to improve timeliness, accuracy and minimize redundancies.

AmeriHealth Caritas is committed to being an effective partner and will continuously strive to improve our policies and processes in an effort to improve outcomes efficiently.

2. Describe mechanisms to ensure consistent application of review criteria for prior authorization decisions

AmeriHealth Caritas Iowa will ensure consistent application of review criteria for prior authorization decisions through proven comprehensive staff training and IRR testing programs, supplemented by individual and team-training to address identified areas of inconsistency.

Staff training

Training staff instructing UM associates on the use of AmeriHealth Caritas Iowa medical necessity criteria complete the InterQual Certified Instructor program to certify them to train and re-train AmeriHealth Caritas Iowa UM staff, physicians and behavioral health doctors on appropriate use of AmeriHealth Caritas Iowa's medical necessity criteria. All associates involved in UM determinations receive initial InterQual certification training as part of their initial orientation. Annually, all staff receive refresher training to update their skills and receive education on any new aspects of the criteria.

In addition, medical directors convene educational sessions quarterly. Topics of discussion include:

- Cases that were denied and overturned on appeal, or dispute by another medical director.

- Cases associated with inconsistencies in determinations.
- Problematic or instructive cases.
- Appeal and dispute cases with special interest to network needs and provider relations.
- Criteria, including those from InterQual, local sources or the corporate clinical policy committee that may have variation in interpretation or application.
- Special reports by medical directors, based on their education, training and experience.
- New information, including:
    - InterQual and health plan-specific criteria.
    - Nationally-recognized guidelines, such as those from the American College of Cardiology/American Heart Association, American Diabetes Association, and National Heart, Lung and Blood Institute.
    - Relevant peer-reviewed medical literature.
    - Clinical policies written using evidence-based literature.

Inter-rater reliability testing

All clinical UM staff involved in the application of medical necessity criteria will participate in an IRR process twice a year.

The inter-rater reliability testing is a written assessment based on specific case examples. Questions are created that test the individual's use of appropriate IQ criteria selection and specific criteria points. Separate assessments are created and administered for staff involved in medical necessity determinations and psychosocial necessity determinations to ensure cases presented during the assessment apply to the request types handled by the associate being assessed.

The inter-rater reliability process involves reviewing blinded actual case examples to ensure non-physician staff are selecting the appropriate criteria and are either approving or pending the cases to a physician reviewer or behavioral health provider for approval if criteria appear to have not been met. Physician reviewers and behavioral health providers also participate in an inter-rater reliability process twice per year.

The inter-rater reliability process helps identify how well and consistently users apply the criteria, whether clarification or recommendations for modifying criteria are needed or whether additional individual or group training is indicated. Action plans are developed to address identified variances. Performance results and action plan results are communicated to staff via individual sessions, team meetings and departmental communications. The results are then reported to the QCCC.

3. Describe processes for retrospective utilization monitoring for IDPH population services

AmeriHealth Caritas Iowa will monitor utilization patterns for the Iowa Department of Public Health (IDPH) substance abuse population through the data and analytical systems used to support our medical expense and trend reporting. The report will be based on paid claims and membership data. It will outline the expense, utilization, and unit cost trends for treatment categories including inpatient, outpatient, professional and retail pharmacy services. Additional data levels will be available to view utilization in the context of age, gender, race, ethnicity, ZIP code, treating provider and diagnosis group, among others.

4. Describe required staff qualifications for UM staff

AmeriHealth Caritas will employ a combination of non-clinical staff and clinical staff including physicians, pharmacists and psychologists, to support the UM program. All staff are regularly trained and tested in cultural competency to ensure that all of our members can receive effective care.

Clinical staff

Our clinical staff will include registered nurses and licensed behavioral health clinicians with varied clinical backgrounds. We often hire UM staff directly from the provider setting. These staff members bring unique knowledge of the processes and practices used in physician offices, hospitals and outpatient healthcare settings. This gives them additional insight to the provider's perspective and needs.

To ensure appropriate expertise in handling requests for psychosocial medical necessity, clinical associates handling behavioral health requests will be experienced behavioral health professionals including registered nurses, licensed clinical social workers, licensed social workers, licensed marriage and family therapists, certified addictions counselors and/or licensed professional counselors. Behavioral health UM associates have a minimum of two years of experience in a clinical psychiatric or chemical dependency setting and may have UM, care management or quality improvement/assurance experience. Behavioral health utilization associates have expert knowledge of managed care concepts and practices have demonstrated the ability to maintain professional relationships and have effective communications with providers, families and facilities.

Non-clinical staff

Our non-clinical and intake staff will answer phones, begin the documentation process for authorization requests and answer basic questions. When hiring, we seek candidates who have a minimum high school diploma/GED, previous call center experience and medical terminology knowledge. All staff also undergo rigorous training and ongoing auditing.

Medical directors and behavioral health medical directors

AmeriHealth Caritas Iowa will hire physicians and behavioral health physicians/psychologists as medical directors and behavioral health medical directors, respectively. In addition to licensure in the state of Iowa, we will seek individuals with a minimum of five years of clinical practice experience, clinical expertise related to the delivery of healthcare services to those most in need and a desire to improve health outcomes in that population. Where appropriate, based on the training and licensure available, we will seek board-certified professionals in these roles.

5. Describe proposed utilization management clinical standards, including the use of any nationally recognized evidence based practices

AmeriHealth Caritas Iowa's UM program will employ nationally - recognized clinical criteria and guidelines that are reviewed by local practitioners for applicability to Iowa. Recommended criteria and guidelines are reviewed upon initial adoption and at least annually thereafter. The QCCC, including practicing Iowa practitioners as members with voting privileges, will be responsible for the annual review and approval of AmeriHealth Caritas Iowa's medical necessity and psychosocial necessity criteria as part of the QAPI program. Practitioners who serve on this committee will provide input in the development and revision of these criteria. Formal approval is obtained from the QAPI Committee, which includes community-based

practicing physicians in primary and specialty care. After internal approval, the criteria will be forwarded to the Iowa DHS for review and approval.

AmeriHealth Caritas Iowa proposes to use the following criteria for medical necessity and psychosocial necessity decision making:

- InterQual Level of Care Acute Adult Criteria.
- InterQual Level of Care Acute Pediatric Criteria.
- InterQual Level of Care Outpatient Rehabilitation and Chiropractic Criteria.
- InterQual Home Care Criteria.
- InterQual Care Planning Procedures Adult Criteria.
- InterQual Care Planning Procedures Pediatric Criteria.
- InterQual DME Criteria.
- InterQual Level of Care Rehabilitation Criteria.
- InterQual Level of Care Subacute and Skilled Nursing Facility Criteria.
- InterQual Level of Care Criteria Behavioral Health Psychiatry Geriatric.
- InterQual Level of Care Criteria Behavioral Health Psychiatry Adult.
- InterQual Level of Care Criteria Behavioral Health Psychiatry Adolescent.
- InterQual Level of Care Criteria Behavioral Health Psychiatry Child.
- InterQual Level of Care Criteria Behavioral Health Residential & Community Based Treatment.
- American Society of Addiction Medicine (ASAM) Criteria.
- NIA Radiology Guidelines.
- AmeriHealth corporate clinical policies.

As needed, AmeriHealth Caritas Iowa will develop internal criteria to supplement InterQual. We will use the following information sources during the development process for our clinical policies:

- Results of the Hayes Incorporated (Hayes, Inc.) technology assessment report.
- Information from appropriate government regulatory bodies, such as the Food and Drug Administration (FDA) or the Department of Community Health.
- Published scientific evidence.
- Publicly available reference information (including Web/online resources).
- Information from a board-certified consultant(s) familiar with the specialty or technology area under review.

The Clinical Policy department is responsible for the production of evidence-based clinical policies which:

- Supplement InterQual criteria for utilization review.
- Are evidence-based, using the hierarchy of evidence provided by the AHRQ.
- Are publically accessible so members, providers and suppliers can be informed on the reviews by AmeriHealth Caritas Iowa.
- Allow for input from providers, members and the public.

The Clinical Policy department receives requests for research on clinical topics internally from UM, Claims, and Provider Network departments, or externally from providers and suppliers. Topics are researched by the writers of the Clinical Policy department using resources such as PubMed, Cochrane Reports, National Institute for Health and Care Excellence (NICE), AHRQ reports, and broad-based literature reviews such as from Hayes, Inc. The clinical policy drafts are reviewed twice by the Clinical Policy Committee (CPC). That committee will include the medical director of AmeriHealth Caritas Iowa along with the medical director from across AmeriHealth Caritas. Representatives from AmeriHealth Caritas' Government Affairs, Compliance, Legal and Pharmacy departments sit on the CPC in an advisory capacity. External comment is encouraged, and both the American Academy of Pediatrics and the American College of Radiology are regular contributors. Beyond that, individual providers and professional associations frequently submit comments and recommendations to the CPC which are considered during the review.

Changes in medical science and technology occur on a rapid basis. All clinical policies are reviewed on an annual basis, but when there is a significant change in medical evidence clinical policies have been reconsidered on a more frequent basis.

The CPC meets monthly to review submitted policies and quality guidelines. Once approved, the clinical policies for Iowa will be modified based upon Iowa Medicaid fee schedule, regulations and Medicaid benefits so that what is displayed on the Provider Portal of the AmeriHealth Caritas Iowa Website is reflective of evidence-based medicine and Iowa Medicaid benefits. This individual tailoring of the clinical policy to Iowa is a unique feature of the AmeriHealth Caritas Iowa policy display. Please see the clinical policy manual and current list of clinical policies on the websites of AmeriHealth Caritas health plans.

The CPC reviews the medical evidence behind requested clinical services to ascertain if they meet the standards of care and state requirements. Currently, AmeriHealth Caritas has nearly two hundred clinical services which have been reviewed using the protocols for evidence evaluation as recommended by the AHQR in determining coverage. This CPC performs annual reviews of existing clinical policies and evaluates new clinical policies. Approved policies are posted publicly on the Provider Web Portal. This transparency makes clinical policies accessible to the physician network and members.

6. Describe how you will identify those services that will be reviewed for medical necessity determination. Provide a list of services for which prior authorization would be required

AmeriHealth Caritas Iowa believes that prior authorization should be used as an inspection process for services that are high-cost and/or have wide variations in how they are used in the community. We are continuously evaluating our prior authorization requirements to reduce the administrative burden the prior authorization process can cause for providers. For services that we see very few denials of care, we lift prior authorization requirements and review utilization through claims data.

Members identified with high utilization patterns are referred to the IHM program for outreach, education and support. Providers that have patterns of care delivery outside of their peers or outside of evidence-based guidelines are contacted by a medical director or behavioral health medical director to review the findings and provide education, as appropriate. When indicated, we refer the provider and/or member to the SIU for additional evaluation.

AmeriHealth Caritas collaborates with our government customers as well as network providers on policies and procedures around authorizations and monitoring for medical necessity. For those services where authorization is required, AmeriHealth Caritas strives to make the process as streamlined and timely as possible to avoid delays in the provision of medically necessary services.

Identifying services that will be reviewed for medical necessity

AmeriHealth Caritas uses a disciplined, evidence-based process to decide which procedures require prior authorization. We review claim and authorization data to understand the services utilized, the variation in service utilization and evidentiary basis available to support the need for the identified service. These processes are also applied to new technology and new uses for existing technology. Based on the outcome of that analysis, services with high cost impact and variable utilization in the population are added to the prior authorization list. Note: All requests for services will be subject to Iowa Medicaid coverage guidelines and limitations.

Services requiring prior authorization

AmeriHealth Caritas Iowa will require medical necessity determination for the following list of services:

- Waiver services:
  - 1915(C) services.
  - 1915(I) habilitation services.
- Elective/non-emergent air ambulance transportation (emergency air ambulance will be reviewed for medical necessity before payment of the claim).
- Diagnostic genetic testing.
- All out-of-network services.
- All inpatient hospital admissions (including medical, surgical, behavioral and rehabilitation).
- Obstetrical admissions/newborn deliveries (exceeding 48 hours after vaginal delivery and 96 hours after caesarean section).
- Elective transfers (for inpatient and/or outpatient services between acute care facilities).
- Long-term acute care.
- Long-term care.
- Home-based services
  - Home healthcare.
  - Skilled nurse visits (SNV) - after six visits per calendar year.
  - Occupational therapy (OT)/physical therapy (PT)/speech therapy (ST) after six visits per calendar year.
  - Home health agency (HHA) authorization from start of care.
  - Nursing services.
- Private duty nursing and personal care services — authorization is required from initiation of service (covered as a benefit under EPSDT as provided through a HHA for up to 16 hours per day).
- Therapy and related services (outpatient).
  - ST, OT and PT (after 12 visits for each modality).
  - Cardiac and pulmonary rehabilitation require authorization from first visit.
- Transplant surgery — organ and tissue.

- All DME rentals
- DME Purchases (for billed charges $500 and over, including prosthetics and orthotics when covered).
- Repairs for member-owned DME items/equipment.
- Hearing services and devices that exceed $500 purchase price may include but are not limited to hearing aids, FM systems and cochlear implants/devices.
- Replacement of hearing aids that are less than four-years-old, except for children under the age of 21.
- Diapers/pull-ups (ages three and above):
    - For quantities over 200 per month (for either or both).
    - For brand-specific diapers.
- Hyperbaric oxygen.
- Gastric restrictive procedures/surgeries.
- 17-P infusion for pregnancy-related complications.
- Gastroenterology services — codes 91110 and 91111 only.
- Surgical services that may be considered cosmetic, including but not limited to:
    - Blepharoplasty.
    - Mastectomy for gynecomastia.
    - Mastoplexy.
    - Maxillofacial.
    - Panniculectomy.
    - Penile prosthesis.
    - Plastic surgery/cosmetic dermatology.
    - Reduction mammoplasty.
    - Septoplasty.
- Inpatient hysterectomy.
- Elective terminations of pregnancy.
- Services related to the diagnosis and treatment of Infertility (coverage as identified by the member's benefits).
- Pain Management — external infusion pumps, spinal cord neurostimulators, implantable infusion pumps, radiofrequency ablation and nerve blocks.
- Select radiological exams — EXCLUDES radiological studies that occur during Inpatient, ER and/or observation stays.
    - Positron emission tomography (PET).
    - Magnetic resonance imaging (MRI)/Magnetic resonance angiography (MRA).
    - Nuclear cardiology diagnostic testing.
    - Computed axial tomography (CT/CAT scans) and CT angiography.

- All miscellaneous/unlisted or not otherwise specified codes.
- All services that may be considered experimental and/or investigational.
- All services not listed on the Iowa Medicaid fee schedule.
- Select medications — see formulary.
- Behavioral health
    - Mental health partial hospitalization program.
    - Mental health inpatient admissions.
    - Neuropsychological testing.
    - Psychological testing.
    - Developmental testing.
    - Behavioral health day treatment.
    - Residential treatment (including crisis residential).
    - Electroconvulsive therapy.

Services that do not require prior authorization

The following services will not require prior authorization from AmeriHealth Caritas Iowa:

- Emergency services.
- Women's health specialist (to provide women's routine and preventive healthcare services).
- Diagnosis and treatment of sexually transmitted diseases and other communicable diseases such as tuberculosis and human immunodeficiency rendered by county health departments.
- OB/GYN services for one annual visit and the medically necessary follow up care for a condition(s) detected at that visit (the recipient must use a plan provider for these services).
- Podiatry for diabetics.
- Immunizations by county health departments and participating PCPs.
- Imaging procedures related to ER services, observation care and inpatient care.
- Dialysis.

Services that require notification

Providers will be asked to notify AmeriHealth Caritas Iowa when the following services are delivered:

- Maternity obstetrical services (after the first visit) and outpatient care (includes 30-hour observations).
- Normal newborn deliveries.
- Inpatient hospital detoxification admissions (within 24 hours of admission).
- Behavioral healthcare management.
- Peer support.

7. Describe your prior authorization request tracking system

UM uses a member-centric population health management system to enter and track all authorizations. With this application, we are able to assign users a specific role or roles that control access to types of episodes with additional confidentiality and sensitivity requirements such as behavioral health services and quality investigations.

When a request for service comes in via phone, fax or mail, images of all documents associated with the request are attached to the episode of care, creating a single source of information and providing efficiency in the review process. Each authorization episode contains the diagnosis code and description, service type, service start dates and end dates, requesting/referring provider, the treating or servicing provider and when applicable service codes including CPT, HCPC, ICD9 (the application is ICD-10 ready),.

The system allows us to easily record and track utilization by provider, as we use one episode per treating provider for outpatient services. The single episode will contain all associated documents and notes for the initial request for service and each extension request. This approach helps us keep all of the history related to the episode of care in the same place, reducing the need for the provider to resubmit prior documentation when requesting an extension.

The notes entered into each episode are date and time stamped. They include the user ID, name, role and title of the person who entered the note. Note templates are used to assist with ensuring all required documentation is included with the entry. Templates include areas that identify how and who made the request for service, what service is requested, past medical history and supporting clinical information. Each user signs their note with their name, credentials (if applicable) and title/role.

Inpatient requests are processed in a similar manner; however, instead of one episode per provider, it is one episode per inpatient stay.

Medical necessity reviews are accomplished by utilizing InterQual criteria which is seamlessly accessed through the system while completing the workflow to document the coverage request. The InterQual review is interactive. The criteria elements selected to complete the review are saved. Separate InterQual records are created for the initial request and each extension or continued stay request.

The application also supports tracking of timeliness by capturing the time each step is completed and calculating the elapsed time against the requirement for that type of request (standard, expedited or retrospective). In addition, AmeriHealth Caritas Iowa uses activities and/or alerts that remind individual users to complete reviews within the timeliness requirements.

A variety of episode types are available including inpatient, outpatient, appeals, behavioral health, care management and physician review. Through the use of assessment tools, AmeriHealth Caritas Iowa will be able to gather specific information related to reviews, notification and/or a member's individual needs as part of the care management referral process. This allows AmeriHealth Caritas Iowa to address of all the member's needs in one application, improving communication between functional areas and supporting our IHM model.

UM associates can also generate correspondence associated with a service or stay request, and/or care management activities. Some examples of letters used include: admission notification letters to PCPs, approval letters and notice of action/denial letters.

AmeriHealth Caritas Iowa is able to obtain reporting from our medical management application using any of the collected data elements. The reporting capabilities allow AmeriHealth Caritas Iowa to monitor utilization and make adjustments to the prior authorization processes and program based on the trends that are noted.

8. Provide sample notices of action as described in Section 11.2.7

If a request for service is completely denied and/or not approved exactly as requested, AmeriHealth Caritas Iowa sends a notice of action to the member and requesting provider. The notice of action provides information to the member at a fifth grade reading level. The written notice of action will include the following information:

- What action was taken or will be taken which will include information regarding why the request was not approved as it was requested. If the request was completely denied, the notice of action will also include information regarding when the action will take effect.
- Rationale or the reason for the action.
- The member's right to file an appeal and the process to file an appeal.
- Information regarding the member's right to request external review or state fair hearing once all levels of internal appeal have been exhausted, along with information on how to request an external review or state fair hearing.
- Expedited appeal information is necessary when an expedited appeal is available and how to file the expedited appeal.
- Information regarding the member's right to continue services during the appeal process pending the appeal decision, how to request the continuation of covered services and in what circumstances the member may have to pay for the cost of the services.

A sample notice of action is provided as Attachment 11.2-A (at the end of this section). AmeriHealth Caritas will provide the notice of action letter template to DHS for review and approval prior to its use.

9. Indicate if your organization elects not to provide, reimburse for or provide coverage of a counseling or referral service because of an objection on moral or religious grounds

AmeriHealth Caritas Iowa will provide all covered counseling and referral services.

10. Describe your program for ongoing training regarding interpretation and application of the utilization management guidelines

As discussed in Section 11.2.2 above, AmeriHealth Caritas Iowa will provide ongoing training for associates involved in medical necessity and psychosocial necessity determinations on the interpretation and application of UM guidelines.

Certified InterQual instructors

Staff providing ongoing training on the use of, and updates to, the InterQual criteria will complete the InterQual Certified Instructor program for certification to train and re-train AmeriHealth Caritas Iowa UM staff, physicians and behavioral health doctors on appropriate use of the criteria. Annually, all staff receive refresher training to update their skills and receive education on any new aspects of the criteria. As part of the training process, different case examples are reviewed and discussed as a group to ensure common understanding of criteria application.

Medical director shared learning

In addition, medical directors hold quarterly educational sessions to work through other cases of interest in the group setting. Topics of discussion include:

- Cases that were denied and overturned on appeal or dispute by another medical director.
- Cases associated with inconsistencies in determinations.
- Problematic or instructive cases.
- Appeal and dispute cases with special interest to network needs and provider relations.
- Criteria, including those from InterQual, local sources, or the corporate CPC, that are may have variation in interpretation or application.
- Special reports by medical directors, based on their education, training and experience.
- New information, including:
    - InterQual and plan-specific criteria.
    - Nationally-recognized guidelines, such as those from the American College of Cardiology/American Heart Association, American Diabetes Association, and National Heart, Lung, and Blood Institute.
    - Relevant peer-reviewed medical literature.
    - Clinical policies written using evidence-based literature.

Inter-rater reliability testing follow-up

As discussed previously, individual and group training is conducted based on the results of bi-annual IRR testing. The IRR testing is a written assessment based on specific case examples. Questions are created that test the individual's use of appropriate IQ criteria selection and specific criteria points. Separate assessments are created and administered for staff involved in medical necessity and psychosocial necessity determinations to ensure that cases presented during the assessment apply to the request types handled by the associate being assessed.

The IRR process helps to identify how well and consistently users apply the criteria, whether clarification or recommendations for modifying criteria are needed, or whether additional individual or group training is indicated. Action plans are developed to address identified variances. Performance results and action plan results are communicated to staff via individual sessions, team meetings and departmental communications, and are reported to the QCCC.

Attachment 11.2-A: Draft Denial Letter

200 Stevens Drive
Philadelphia, PA 19113-1570

|TODAY|
|TRANSLATE TO LANGUAGE|{RBL}
Reference/Tracking Number: |CASE_NUMBER|
LOB UMBDEN {RBL}
{ADDRESS} {RBL}

Provider:	|ref/att/treat|
Member ID Number:	|PATIENT_ID|
Medicaid ID Number:	|PATIENT_MEDICAID_NO|
Admission/Service Date:	|LTR37|
Effective Date:	|LTR22|
Service(s):	|LTR36|

Dear [MBR/PG SAL}:

Based upon the medical information provided to our physician reviewer, {Physician Reviewer}, it has been determined that beginning {LTR22}, the request for **{LTR36}** is denied/cannot be certified.

The reason(s) for this determination is (are) as follows: {LTR161}

This determination was based on: {Reference to applicable criteria (LTR18):}

(All references in this letter to the term "you" or "your" refer solely to the named member.)

You may obtain copies (at no charge) of the medical and other documents on which this decision was based by contacting Member services at {MSPH#} or by sending a request to AmeriHealth Caritas Iowa:

AmeriHealth Caritas Iowa
Attention: Member Advocate
Member Appeal Department
200 Stevens Drive
Philadelphia, PA 19113-1570

If your provider would like to discuss this case with a reviewer, please have him or her call the Medical Management Department at 1-800-XXX-XXXX or XXXXXXXXXXX (TTY).

If you disagree with this decision, you have the right to appeal it. There are two ways in which you may appeal: an expedited appeal or a standard appeal.

Expedited Appeal

If you or your provider believes your appeal is an emergency and that it would be harmful or painful to you if you had to wait for a standard appeal to be decided, you or your provider may request an expedited appeal by AmeriHealth Caritas Iowa. If you want your provider to represent you, you must give your provider written permission to do so.

An expedited appeal can be requested by calling AmeriHealth Caritas Iowa Member Services department at |MSPH#|. You or your provider can fax documents to support your appeal to AmeriHealth Caritas Iowa Appeal department at 1-888-XXX-XXXX. You will be notified of AmeriHealth Caritas Iowa's decision as soon as possible, but no later than three (3) calendar days after AmeriHealth Caritas Iowa receives your request for an expedited appeal.

Standard Appeal

You or your provider have the right to appeal this decision to AmeriHealth Caritas Iowa within 30 calendar days of the date at the top of this letter by calling Member Services at |MSPH#|, by faxing your request to 1-888-XXX-XXXX or by sending a written notice to:

AmeriHealth Caritas Iowa
Attention: Member Advocate
Member Appeal Department
200 Stevens Drive
Philadelphia, PA 19113-1570

You may receive assistance from Member Services at |MSPH#| in filing your appeal or may contact the Iowa Department of Human Services directly.

If you file your appeal by telephone, you must follow up your call with a written, signed appeal letter. AmeriHealth Caritas Iowa will help you by writing this appeal letter and sending it to you for your signature.

If you want your provider to represent you, you must give your provider written permission.

If you wish to have your benefits continue during the appeal, you must file your request within the later of:

- **Ten days from the postmark on the envelope this letter came in; or**
- **The effective date above.**

You may submit medical information and documents that support your appeal and written comments for review to AmeriHealth Caritas Iowa. You will be notified of the decision in writing within 45 calendar days after AmeriHealth Caritas Iowa receives your appeal.

State Fair Hearing

If you disagree with this decision, you, your provider or other representative (such as a family member or a lawyer) have the right to request a State Fair Hearing before the Department of Human Service Appeals Section. You must request a State Fair Hearing within 90 days of the date at the top of this letter.

12. Program Integrity

Please explain how you propose to execute Section 12 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Overview

As a people-to-people organization, AmeriHealth Caritas Family of Companies (AmeriHealth Caritas) is built on a foundation of trust earned through the commitment to ethics and honor with which we conduct our business. Our operational practices are measured by the highest standards, and we comply fully with all applicable federal and State requirements.

> Our next generation model of healthcare relies not just on integrity of thought and care, but also on integrity of process and structure.

Throughout AmeriHealth Caritas, we have adopted a compliance program to encourage collaborative participation at all levels and to stimulate a culture of compliance, which will include the designation of an AmeriHealth Caritas Iowa compliance officer and Compliance Committee accountable to senior leadership. The compliance program fosters an environment that requires associates to comply with all relevant laws and regulations and appropriately report any concerns about business and operational practices. In addition to focusing on compliance from associates, AmeriHealth Caritas has an established, comprehensive Fraud and Abuse Operations program to prevent, detect, investigate and mitigate fraud, waste and abuse (FWA) by providers and members, which will be implemented by AmeriHealth Caritas Iowa.

Our program is developed in accordance with 42 CFR 438.608, 42 CFR 455, Section 12 of this RFP, and all relevant state and federal laws, regulations, policies, procedures and guidance (including CMS Guidelines for Performance Standard for Referrals of Suspected Fraud from a Single State Agency to a Medicaid Fraud Control Unit). Our program includes adequate staffing to carry out our integrity plan. In addition, a Program Integrity manager — dedicated to the oversight and coordination of program integrity efforts — will be located in Iowa and along with the compliance officer will partner directly with the State to meet all the requirements.

A draft of AmeriHealth Caritas Iowa's Compliance Program , is attached (Attachment 12.0-A: Draft AmeriHealth Caritas Iowa Compliance Program).

AmeriHealth Caritas Iowa will comply with all needs stated within this section, including areas not specifically addressed in the questions below.

1. Describe your procedures for avoiding, detecting and reporting suspected fraud and abuse to the State.

Organization and tools

Program Integrity Department architecture

The Program Integrity Department (PID) uses external vendors and subcontractors, as well as internal methods, to detect FWA. The diagram below illustrates the overall architecture of the PID and operates as

part of cost avoidance, retrospective recovery and investigation and reporting by the Special Investigations Unit (SIU).

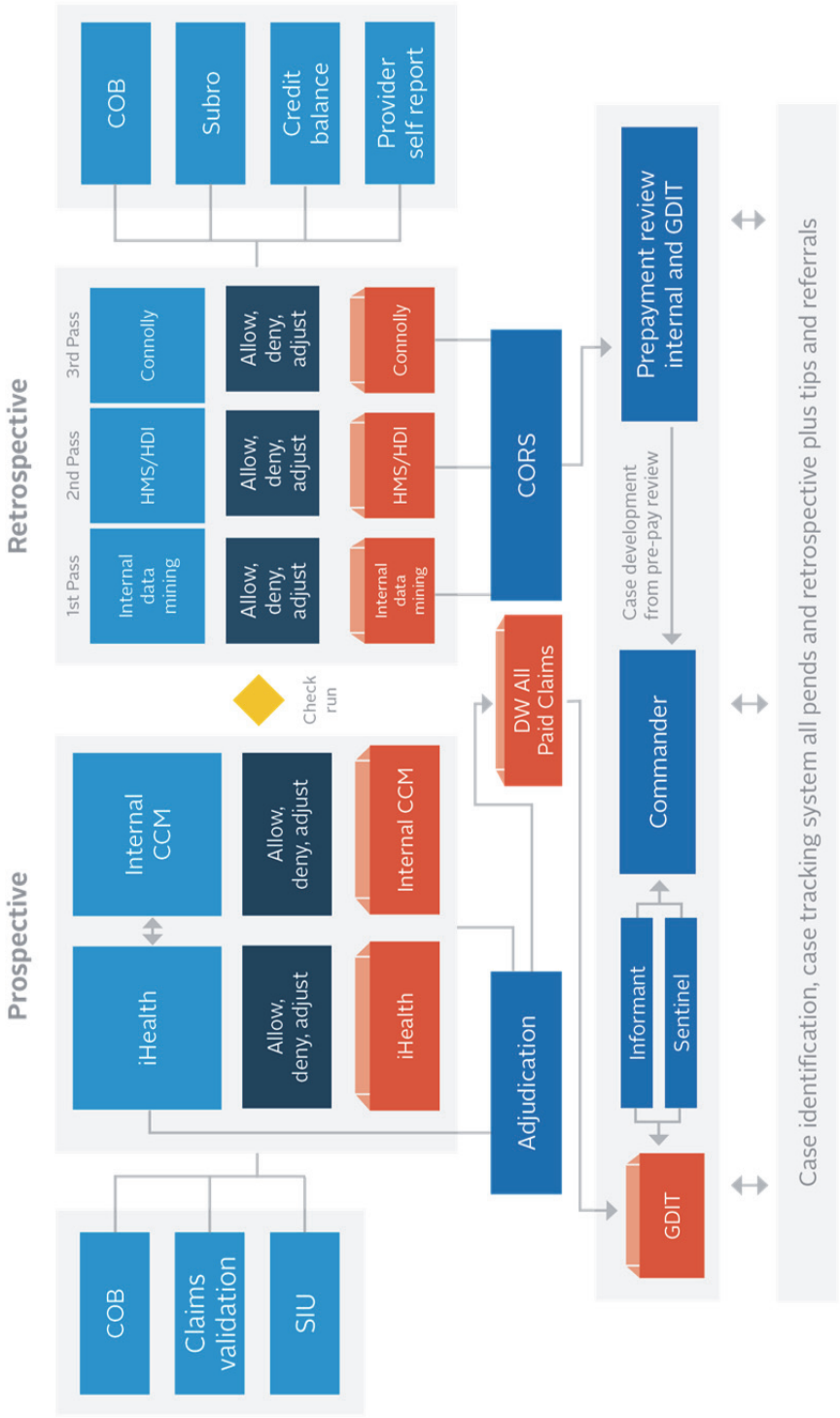

Exhibit 12.1-A: PID Architecture

Prospective cost avoidance operations

The Payment Integrity department utilizes an internal process and an external vendor to perform claim editing before check runs to increase the accuracy of paying claims. Medical directors, as well as provider network management (PNM) associates, review and approve all clinical cost avoidance edits prior to deployment. The process includes high-priority claim tagging to ensure timely and accurate payments to providers.

Internal claims cost management

The internal claims cost management (CCM) process includes an internal data mining system that runs a post-adjudication, pre-check run for all of our health plans. The edits are developed to maintain compliance with provider contract language, individual state Medicaid and CMS reimbursement methodologies, system configuration issues and detect provider billing errors. As part of the process, AmeriHealth Caritas has certified clinical coders who review claims and medical records to provide new areas for prepay algorithm development, affording continuous improvements and innovation to the process.

iHealth Technologies

All outpatient, professional and durable medical equipment (DME) claims pass through iHealth Technologies (iHT) analytics engines post-adjudicated and pre-check run on a daily basis. This first-pass, external vendor process denies, reduces or allows claims to be paid. As part of the process, and on a monthly basis, all denied and reduced claims are reviewed. Included in this process is the introduction of new clinical edits that are reviewed by AmeriHealth Caritas Family of Companies medical directors and PNM associates.

Retrospective data mining and recovery operations

The Payment Integrity department utilizes both internal and external sources to perform data mining for FWA. Data mining and recovery operations use distinct processes, performed by internal staff, with queries focused on the following potential overcharges targeted for recovery:

- Outpatient charges during inpatient stay.
- Payment greater than billed charges.
- Duplicates.
- Incorrect coordination of benefits (COB) payment.

Health Management Solutions coordination of benefits identification and recovery

On a weekly basis, claims, member eligibility, provider and third-party liability (TPL) files are sent to Health Management Solutions (HMS) to identify additional TPL information for our Medicaid members. Additionally, HMS will bill liable, primary and third-party carriers to recover claim payments.

HMS data mining and recovery

Utilizing the files referenced above, HMS uses sophisticated analytics to identify potential overpayments from professional, outpatient, facility and DME claims. These overpayments are posted into the AmeriHealth Caritas Claims Overpayment Recovery System (CORS). Providers receive overpayment request letters with descriptions of the overpayments and information regarding how to dispute the findings — a majority of the overpayments are recovered by offsetting future claims.

Connolly data mining and recovery

Connolly Data Mining and Recovery (Connolly) operates similarly to HMS. Connolly reviews claims using additional sophisticated analytics and is referred to as our third-pass vendor.

Claims Overpayment Recovery System

CORS is an internally-developed, desktop-software application that serves as the record system for a majority of the Payment Integrity department's retrospective recovery activity. It is also used to complete the following claims recovery-related functions:

- Internal generation of project recovery letters to providers.
- Communication and tracking of vendor identified projects.
- Vendor invoicing process.
- Overall internal and external project reporting.

Prevention/cost avoidance

FWA prevention is managed through clinical editing during claims processing and prepayment correct coding edits. The prepayment correct coding edits avoid claims cost that supports FWA reduction. AmeriHealth Caritas has comprehensive systems in place to conduct claims editing for professional and outpatient encounters. Applicable clinical edits are added on a regular basis to the claims processing system, based largely upon National Correct Coding Initiative (NCCI) and American Medical Association (AMA) standards. Inpatient claims are evaluated using a multiple-pass data mining screening to identify overpayments. In addition, predictive scoring models are used on all facility-paid claims to select medical records to be reviewed for claims validation and potential overpayment recoveries.

The medical claim payment policies are based on guidelines from established industry sources, such as CMS, AMA, state regulatory agencies and medical-specialty professional societies. In making claims payment determinations, AmeriHealth Caritas also uses coding terminology and methodologies that are based on accepted industry standards, including the Healthcare Common Procedure Coding System (HCPCS) manual, Current Procedural Terminology (CPT®) codebook, International Statistical Classification of Diseases and Related Health Problems (ICD) manual and the National Uniform Billing Code (NUBC).

In addition to the above, the Special Investigation Unit (SIU) utilizes a prepayment review process to validate services prior to payment, which requires providers suspected of fraud and/or abuse to submit medical records in conjunction with claims. This targeted process ensures accurate payments during SIU investigations.

Detection and investigation

AmeriHealth Caritas' SIU is responsible for detecting FWA throughout our claims payment processes. The scope of the SIU's activities encompass all contracted/non-contracted providers, specifically including the authority to investigate allegations of FWA involving members or other persons, as well as allegations related to the business practices of vendors, contractors and subcontractors. The SIU establishes, distributes, enforces and revises written policies and procedures used by the SIU staff to detect, investigate and fully document allegations of FWA. SIU staffing includes experienced investigative analysts, Certified Professional Coders (CPC), Certified Fraud Examiners (CFE) Accredited Healthcare Fraud Investigators and dedicated legal support to help guide the SIU staff throughout case development. Additionally, AmeriHealth Caritas is a corporate member of the National Health Care Anti-Fraud Association. Through this membership, SIU staff receives multiple training opportunities to keep current on certifications and FWA trends and schemes.

The SIU proactively identifies potential incidents of suspected fraud and abuse as part of its program for ongoing monitoring and auditing. The SIU has procedures in place designed to prevent and detect potential or suspected fraud and abuse in the administration and delivery of services for this Contract. They include the following:

- Ongoing evaluation of claims data to detect abnormalities in provider billing, prior authorizations and member utilization patterns.
- Post-processing review of claims to include participating and non-participating providers.
- Periodic sampling of claims to determine propriety of payments.
- Requirement that providers and subcontractors agree to adhere to program standards regarding FWA as a condition of contracting.
- Dissemination of information to members and providers concerning FWA.
- Encourage reporting of potential FWA through the provider handbook, member handbook and newsletters.
- Pre- and post-payment medical record reviews accompanying claims for SIU identified providers.
- Using peer-to-peer comparisons.
- Using predictive scoring models that identify suspicious providers.
- Searching for scheme-outcome scenarios.

The SIU efforts are supported by industry-leading anti-fraud technology. The SIU utilizes a lead detection and pattern analysis tool providing automated early-warning fraud and abuse detection and overpayment protection capabilities. Rules, algorithms and pattern detection capabilities evaluate, identify, compare and rank providers and members who generate qualified leads for investigation. A case-tracking system provides support for day-to-day investigation coordination, management of dedicated resources and reporting capabilities to ensure compliance with contractual reporting requirements of suspected and/or confirmed fraud or abuse. Ad hoc claims-query capabilities are another important proficiency within the scope of the SIU technological capacity. The SIU also accesses an internal data warehouse, which includes all claims processed, to identify patterns that may indicate FWA. Combined, these tools are used to identify potential FWA, such as:

- Overutilization.
- Upcoding.
- High-dollar claims.
- Unusual patterns by members, providers or facilities.
- Unusual dates of service.
- Excessive time units for time-based codes.
- Unusual claims volume by providers.
- Unbundling of services.
- Incorrect reimbursement to providers, facilities and/or pharmacies.
- Incongruous procedure code, prescription and diagnostic code combinations.

The SIU uses General Dynamics Information Technology (GDIT) STARSSolutions as part of an integrated solution for detection, investigation and prevention of FWA. These solutions, as depicted in the PID architecture, are defined below:

- STARSInformant enables the SIU to export ad hoc claims data to fully support the investigative process.
- STARSSentinel is an outsourced fraud and abuse lead generation solution. AmeriHealth Caritas Iowa's claims will be run through this analytics engine on a monthly basis. The output is based upon statistics and provides the SIU with suspicious providers and members.
- STARSCommander is the case management system used by the SIU. It enables the SIU management team to manage workload/caseload throughout the case lifecycle. Case reporting and status is monitored weekly and monthly with internal management.

The workflow starts with all paid claims. We send up to three (3) years of historical claims to GDIT, where the claims are managed in their data warehouse. The SIU analysts and investigators have the ability to perform ad hoc data mining on STARSInformant to identify abnormal patterns, peer-to-peer comparisons, research tips and referrals. Independently, GDIT runs our claims data through STARSSentinel on a monthly basis. STARSSentinel provides the following information to the SIU:

- Peer-to-peer comparison.
- Predictive scoring for suspicious providers.
- Scheme outcome scenarios.
- Billing rule violations.
- Claims submission frequency comparator.

All cases — through ad hoc data mining, tips and referrals, or STARSSentinel — are logged and tracked in STARSCommander from case initiation through referral and/or closure.

Provisions for prompt response to a detected offense includes a process that ensures a timely referral to appropriate state oversight agencies according to individual state contract requirements, development of an investigative timeline, provider flagging, beneficiary flagging and specific procedure code flagging for verifying service delivery. This may include requiring submission of medical records to validate and justify claim(s) submission prior to payment. The prepayment review process affords the plan the opportunity to pay the claim(s) accurately versus paying and chasing.

The SIU may refer members to AmeriHealth Caritas Iowa's lock-in process when the results of a preliminary investigation reveal pharmacy and medical claims utilization patterns appear abnormally high. Responsive decision-making exists in the clinical judgment of AmeriHealth Caritas Iowa's medical director.

State agency reporting

AmeriHealth Caritas Family of Companies and AmeriHealth Caritas Iowa will follow state-mandated reporting requirements and establish a cadence for monthly reporting, including payment integrity (cost avoidance and recoveries) and SIU provider case identification, planning and action plans. In addition, the state has requested reporting of suspected fraud or abuse within two (2) days of identification. AmeriHealth Caritas Iowa's SIU is prepared to meet this timeframe in a manner and format deemed appropriate by the state.

This organizational alignment provides transparency for all PID and SIU activities and findings. The Program Integrity manager ensures timely reporting and ongoing updates to the Medical Fraud Control Unit (MFCU) and DHS in accordance with the Medicaid Managed Care Organization (MCO) Contract, and will bring forward investigation summaries to the Compliance Committee. The Program Integrity manager reviews and addresses requests for information relating to FWA, including losses, recoveries and provider terminations. Reporting will include, but is not limited to:

- The name and national provider identifier (NPI) of reviewed provider.
- The reason for the review, including data source and/or referral.
- Review outcome.
- Provider referrals to MFCU.
- Providers suspended and reason for suspension.
- Providers terminated and reason for termination.
- Provider recoupment amount and reason for recoupment.
- Provider payment reductions and reason for payment reduction.
- Providers who were denied enrollment or reenrollment pursuant to 42 CFR 455, including provider name, NPI and reason for denial.
- State fiscal year-to-date summary information of contractor program integrity activity.

Referral to law enforcement

The primary goal of referring a case to a law enforcement agency is to obtain a conviction. In the prosecution of fraud cases, the SIU pledges full cooperation with local, state and federal law enforcement agencies, as well as with state insurance fraud departments, state Medicaid fraud control units and state Medicaid program integrity units. If the prosecution is successful, restitution will be consistently pursued as an element of judgment in coordination with state and federal victim protection boards.

The SIU will refer law enforcement to any transaction where the facts and circumstances create a reasonable belief that a person or entity may have committed or is committing fraud and/or abuse. Such referrals will be submitted in a standardized format or as mandated by a particular law enforcement agency.

The SIU will refer suspected or confirmed fraud or abuse, in addition to suspected neglect/abuse (mistreatment) of a member, to appropriate oversight agencies within the required timeframes. AmeriHealth Caritas Iowa will also monitor all communications from DHS and suspend payment to any provider that is on payment hold under the authority of DHS or its authorized agent(s).

2. Provide examples of outcomes achieved in other states regarding program integrity efforts.

The focus of the PID is on prospective savings, cost-avoidance opportunities and retrospective overpayment recoveries. In 2014 alone, for the AmeriHealth Caritas PID activities in Indiana, Louisiana, Nebraska, Pennsylvania, South Carolina, and Washington D.C, our program integrity efforts delivered savings of over $274 million. A high-level summary of some the prospective and retrospective outcomes and results from our PID services we provide to other states is set forth below:

- Prospective coordination of benefits cost avoidance – $132.3 million
- Claims cost management cost avoidance - $13.1 million
- Complex/medical record review cost avoidance - $1.6 million
- Prepay clinical editing cost avoidance - $38.6 million
- Special Investigations Unit prepay review cost avoidance - $1.2 million

At the end of calendar year 2013, prospective savings for Medicaid plans totaled $132.4 million. For 2014, the total was $186.8 million, as shown in Exhibit 12.2-A.

- Retrospective COB overpayment recoveries - $15.9 million
- Subrogation overpayment recoveries - $3.3 million
- Facility Credit balance overpayment recoveries - $4.4 million
- Provider self-reports overpayment recoveries - $5.7 million
- Data mining/audit recoveries - $52.9 million
- Complex/Medical Record Review and claim validationoverpayment recoveries - $4.3 million
- Special Investigations Unit overpayment recoveries - $1.1 million

Retrospective recoveries for AmeriHealth Caritas totaled $74.2 million at the end of calendar year 2013, and a total of $87.5 million for 2014, as shown in Exhibit 12.2-A.

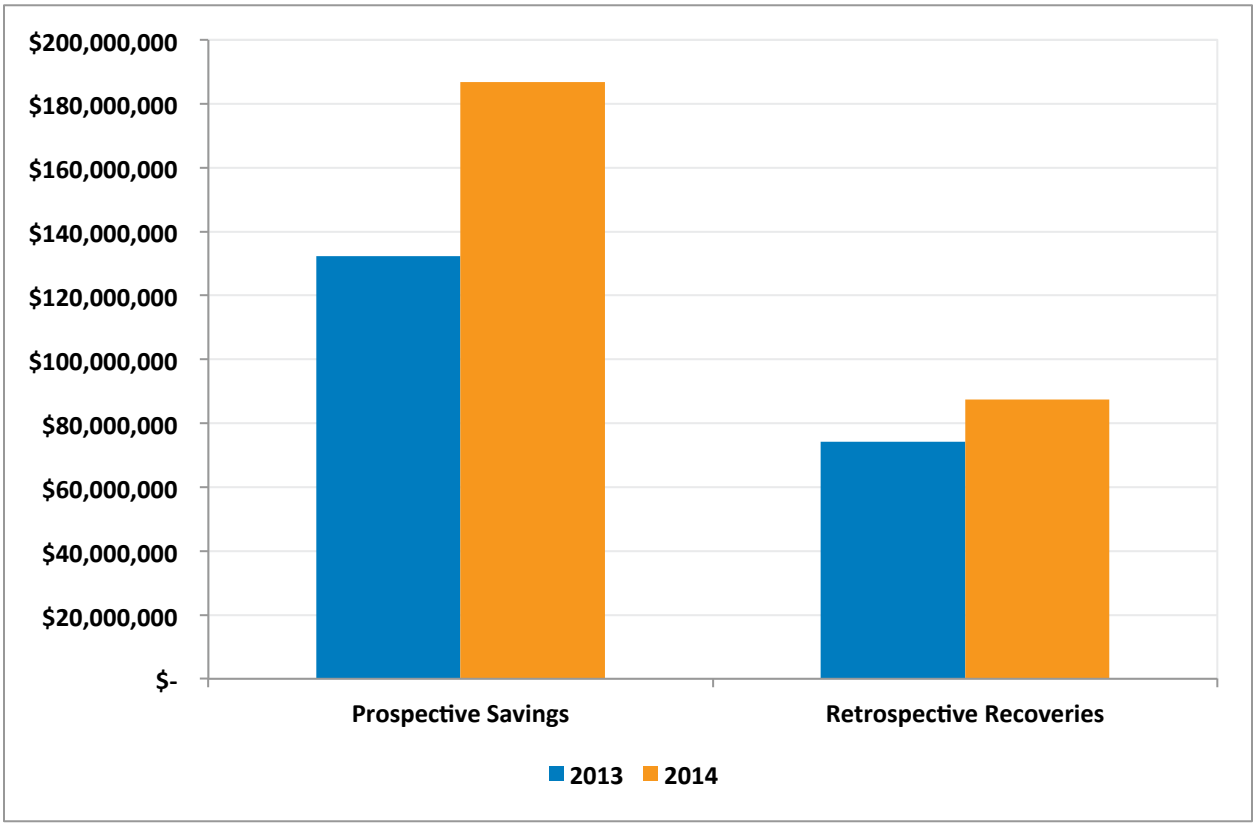

Exhibit 12.2-A: Prospective and Retrospective savings 2013-2014

Examples of recent case studies currently in investigation within AmeriHealth Caritas

Example 1: PCP

Primary care providers (PCPs) were identified as outliers for billing diagnostic testing (radiology and lab tests), as well as a high frequency upcoding of evaluation and management (E/M). The initial data analysis reflected similar billing patterns for members at each visit and identified duplicate tests being performed

at unexpected intervals. A probe record review confirmed the allegation of excessive diagnostic testing and upcoding, as well as a lack of documentation to support the necessity or practicality of the services. A referral was sent to the state Medicaid Program Integrity and Fraud Control departments. The investigation was expanded to include medical record review using a statistically valid random sample (SVRS). Additional records were requested from the provider. A certified nurse coder received and reviewed the records, which confirmed the results of the probe sample. An addendum to the initial referral was forwarded to the state, and the provider was placed on prepayment review. The case is currently in active investigative status and awaiting mediation/arbitration. A final overpayment demand was forwarded to the provider for $503,000.

Example 2: OB/GYN

An OB/GYN provider was identified through SIU data mining as an outlier for the billing of 99215 E/M code. A SVRS sample was pulled from the provider's 99215 claims and a request for records was sent to and received by the provider. Clinical review of the records confirmed 1) the allegation of upcoding; 2) the documentation did not support the billing of the 99215 services; 3) 40 out of 41 claims were not supported by the documentation; and 4) no documentation was received for one (1) out of 41 claims. The case was referred to the state Medicaid Program Integrity department and MFCU. A final identified overpayment of $42,000 was recovered.

Example 3: Pain management provider

A pain management provider was identified through SIU data mining as an outlier for billing excessive urine drug screens (UDS). An SVRS was pulled for a two-year period. Records were received and reviewed. An onsite visit revealed the provider office had opened its own lab, and was performing unnecessary quantitative testing simultaneously with the initial qualitative screening without regard to the initial results. The case was referred to the state Medicaid Program Integrity department and MFCU, which is currently in an active investigative status. An identified overpayment of $715,000 is being pursued.

Example 4: Physical therapist

A physical therapist was identified through SIU data mining as an outlier for billing excessive physical therapy (PT) services. An SVRS of the provider's claims was pulled. Records were requested and received. Review of the records revealed the provider's documentation did not contain necessary elements for the billed CPT codes, including direct one-on-one patient contact, stated time per modalities, orders and plan of care. The case was referred to the state Medicaid Program Integrity department and MFCU. Final overpayment demand of $100,000 was forwarded to the provider. The case remains active and the SIU is pursuing the overpayment.

3. Describe methods for educating employees, network providers and members on fraud and abuse identification and reporting.

AmeriHealth Caritas Iowa's training systems will include education and guidance on our ethics and legal compliance policies; the Code of Conduct; fraud, waste, and abuse (FWA) issues and procedures; and the reporting and investigation of compliance issues. This includes the use of a confidential toll-free telephone line for all associates, contractors and consultants. AmeriHealth Caritas Iowa will have a policy concerning disciplinary action for noncompliance with the Code of Conduct.

Employees will complete new hire training within 30 days of the beginning date of employment in the following areas:

- Code of Ethics and Conduct.

- Privacy and Security, including the Health Insurance Portability and Accountability Act.
- FWA.
- Procedures for timely, consistent exchange of information and collaboration with DHS.
- Organizational chart, including the compliance organization and the program integrity management and investigators.
- Provisions that comply with 42 CFR §438.610 and all relevant state and federal laws, regulations, policies, procedures and guidelines issued by the Iowa DHS, US Department of HHS, CMS and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by Iowa or its departments.

As a condition of continued employment, every associate undergoes annual training on the Code of Ethics and Conduct. Upon hire and annually thereafter, all associates are required to complete training of the Deficit Reduction Act (DRA), the Fraud Enforcement and Recovery Act (FERA), the Affordable Care Act (ACA), the Dodd-Frank Act and the False Claims Act (FCA), which highlights state and federal FCA requirements. Through these courses, associates are educated on the FCA and its pertinence to fraud and abuse in Medicaid programs. The courses also focus on specific provisions for whistleblower protections and provide resources to help them remain compliant with federal and state FCA laws.

The training program includes the SIU's mission and purpose, identification of suspicious fraud, waste and/or abuse scenarios and the SIU referral process. The provisions of the targeted FWA and other related training are provided by the SIU upon request, or otherwise as necessary. Annually, as a condition of continued employment, every associate (including fulltime, part-time and temporary associates) undergoes training on the Code of Conduct. The Code of Conduct instructs associates to report suspected FWA to the SIU.

AmeriHealth Caritas Iowa is committed to combatting FWA. As with other AmeriHealth Caritas plans, AmeriHealth Caritas Iowa will provide additional training to its associates via mandatory educational sessions and quarterly compliance newsletters. Topics include compliance, FWA reporting and DHS contract requirements. For SIU associates, they are provided training opportunities to enhance their skill set and knowledge base. Investigators attend in-person and online education sessions and training provided through the National Health Care Anti-Fraud Association.

Training information is available on-demand to providers via our plan website as well as through the provider manual, which includes information on how to stay compliant with state and federal laws combating FWA. This information is reviewed in depth with new providers. Providers are also directed to our website to become familiar with the broad range of educational topics we offer. At any time, providers are able to contact their assigned Provider Network Management account executive for education, follow-up questions and concerns. Information available through the website is reviewed and updated regularly.

In addition to our robust associate and provider training, AmeriHealth Caritas Iowa members will be educated regarding fraud and abuse through their initial enrollment, onboarding materials and regular communications with AmeriHealth Caritas Iowa.

Our provider manual is available electronically on our plan website and can be downloaded for those who prefer a hard-copy version. The provider manual and all provider-related materials, including the provider section of our website, are reviewed regularly to ensure information is current and concise. As an example of our policies and training, please refer to the provider manual information contained in Section 6 of this response.

4. Describe internal controls to ensure claims are submitted and payments are made properly.

AmeriHealth Caritas Iowa's contracts with providers require prompt notification to AmeriHealth Caritas Family of Companies if the provider is debarred or suspended from participation in Medicaid/Medicare, the Children's Health Insurance Program (CHIP) and/or any federal healthcare program. Such contracts also contain provisions that require prompt notification to AmeriHealth Caritas Iowa of any felony convictions or other changes in status that materially affect the provider's ability to perform under the contract. Upon receipt of such notification, as appropriate, AmeriHealth Caritas Iowa terminates its contractual relationship with the provider. Compliance is also assured through the credentialing and re-credentialing process.

The SIU has an excluded and sanctioned provider process across the enterprise. The SIU has established a screening process to review all participating and nonparticipating providers. On a monthly basis, AmeriHealth Caritas Family of Companies provides all provider files to two Payment Integrity vendors (Optum and Provider Trust) that screen for all federal (OIG LEIE and GSA SAM) and state exclusions and sanctions.

All practitioners and facilities identified by these vendors are immediately configured within the AmeriHealth Caritas Family of Companies' adjudication platform to deny their submitted claims. Additionally, excluded practitioners and facilities that submitted claims that were denied after the effective date of the exclusion are transferred to the SIU for investigation.

Any new non-participating provider (practitioner or facility) submitting a claim goes through a validation process to ensure the provider is not on the excluded/sanctioned provider list. This is accomplished during the initial steps of claims adjudication, where claims processors access Optum and ProviderTrust validation portals to validate the provider. AmeriHealth Caritas Iowa will also screen new participating and non-participating providers using the websites listed in the section above.

AmeriHealth Caritas Iowa also coordinates with DHS Program Integrity to maintain member and provider data integrity and remove incarcerated, deceased or incorrectly enrolled members or providers. In order to support the maintenance of accurate and complete provider data and to support the efforts described above, AmeriHealth Caritas Iowa is also developing an internal mechanism to monitor providers on an ongoing basis.

Provider suspension

AmeriHealth Caritas Iowa shall comply with 42 CFR 455.23 by suspending all payments to a provider after the Agency determines a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity, unless the Agency or law enforcement (included but not limited to the MFCU) has identified cause not to suspend payments, in part or in full, in writing.

Upon notification, AmeriHealth Caritas Iowa shall issue a notice of payment suspension that comports in all respects with the obligations set forth in 42 CFR 455.23(b) and maintains the suspension for the period set forth in 42 CFR 455.23(c). In addition, the notice of payment suspension shall state that payments are being withheld in accordance with 42 CFR 455.23. AmeriHealth Caritas Iowa will not suspend payments until consulting with the MFCU and the Agency.

AmeriHealth Caritas Iowa will afford a grievance process to providers for whom payments have been suspended by the Contractor, which adheres with all state requirements.

AmeriHealth Caritas Iowa will maintain all materials related to payment suspensions for a minimum of five (5) years in compliance with the obligations set forth in 42 CFR 455.23(g).

Service verification

On a monthly basis, AmeriHealth Caritas Iowa mails service verification letters to a group of members for whom claims are received. Using state-approved sampling methodology, AmeriHealth Caritas Iowa generates notices, which include a description of the service provided, the provider of said service, date on which the service occurred and the amount of payment made. AmeriHealth Caritas Iowa ensures that a minimum of one (1) percent of all paid claims in a given month are represented in this sample. AmeriHealth Caritas Iowa tracks all complaints received by the Member Services department, as well as any actions taken as a result of an inquiry. We will report the results to DHS on a quarterly basis or as required, and utilize the results to target high-risk provider types and/or services. In cases where survey results indicate unreceived paid services, AmeriHealth Caritas Iowa will forward all required information to SIU and DHS for review

Ensuring completeness of claims data

AmeriHealth Caritas Iowa will implement defined processes to ensure all claims submitted by providers are processed appropriately and that claim acknowledgements are returned to providers. AmeriHealth Caritas Iowa will accept claims submitted via electronic data interface (EDI) methods or on paper claim forms, which are converted to electronic format for processing through our adjudication system.

Provider claims reconciled upon receipt

AmeriHealth Caritas Iowa's clearinghouse will validate submitted claims to identify missing and invalid required fields. Claims lacking HIPAA compliant data fields will be rejected and returned to the provider. Claim acknowledgements will be returned to providers via the clearinghouse for EDI submitted claims. A control process will acknowledge all claims received.

For our paper clearinghouse, a similar validation is performed to identify any missing or invalid data fields. A rejection letter will be generated informing the provider of all the reasons for the rejection(s), and be accompanied by a copy of the claim form submitted. A copy of both the rejection letter and claim will be sent by AmeriHealth Caritas Iowa via an XML file for storage in the SunGard EXP MACESS tool. EXP MACESS is an imaging-based operations management, workflow management, enterprise content management and customer-service solution that has been standardized for managed healthcare organizations.

Once processed through the clearinghouses, the claims will then be loaded into Facets, which will verify the completeness and accuracy of provider numbers, member ID numbers, diagnosis codes and procedure codes.

Reconciling pended, paid or denied claims to remittance advices

The claims processing system will set the claim to a status of pend, deny or ready for payment. Pended claims require a manual review before adjudication can be finalized, and will be routed to claims examiners via an automated workflow system. The workflow system will track each pended claim until adjudication is finalized. If a claim is denied because the provider did not submit required information or documentation with the claim, then the remittance communication will identify all missing information and documentation. The resubmission of a claim with further information and/or documentation will not constitute a new claim for purposes of timely filing. The remittance advice (RA) will include information on all claims paid, denied and adjusted during the claim payment cycle. The associated payment to the provider will consist of the net of all debits and credits.

Support for electronic data interface

AmeriHealth Caritas Iowa will maximize claims submission via EDI, encouraging providers to utilize electronic claims submission, use electronic funds transfer (EFT) for payment and adopt electronic remittance advice. These electronic claims will be submitted through secure, web-based portals, such as Emdeon's Provider WebConnectSM. These portals enable providers to improve practice efficiency and reduce expenses through real-time access to key administrative transactions, such as:

- Claim inquiries.
- Electronic referrals.
- Eligibility inquiry, including benefit verification.

Optical character recognition of paper claims

AmeriHealth Caritas Iowa's paper claims will be converted into electronic data by a vendor that uses optical character recognition (OCR) and performs a character repair function. Claims that do not pass OCR will be keyed through a data-capture application. The vendor and AmeriHealth Caritas Iowa's quality auditors will separately pull a sample of keyed claims monthly to validate quality and accuracy.

Enforcing accuracy of claims data

We will use several strategies to ensure accurate claims data submissions. This will include testing payment configurations, automated editing against a full suite of clinical and administrative rules, maintaining up-to-date system rules and edits and regularly monitoring quality through audit programs.

Claims payment testing strategy

AmeriHealth Caritas Iowa will use a robust testing strategy to ensure the accuracy of claim payments. Payment configuration will be tested when one of the following triggers occurs:

- Initial set-up of providers in a new market.
- Loading of a new provider agreement.
- Introduction of a new payment methodology.
- Identification of trends in claim payment errors.
- Fee-schedule updates.

AmeriHealth Caritas Iowa will utilize the Claim Test Pro application to test claims data and verify that correct claim totals are being paid prior to system updates and changes. Claim Test Pro is a TriZetto solution that greatly reduces the need for manual creation of test data, by electronically converting system data to applicable testing data sets to create a robust and applicable testing environment. The application also automates the management and reconciliation of results, tracks and documents test projects and cases, and creates testing result reports.

Claims processing rules

AmeriHealth Caritas Iowa will develop standard claims-processing rules used during the adjudication process. The standard rules will be tailored to meet state-specific requirements and our provider agreements. Claim examiners will have access to the processing rules to aid them during the adjudication process through our online help software. Processing rules will be updated when new rules are identified and/or when the quality-auditing process has identified specific areas for enhancement.

Compliance with industry standards, state and federal requirements

Claim payment policies will be updated regularly, and updated code files will be loaded into the claim adjudication system generally quarterly or annually, as published.

These updates will be derived from standard industry sources, such as:

- NUBC.
- HCPCS.
- CPT.
- ICD-10 guidelines.
- CMS NCCI manual.
- NCCI facility and professional procedure to procedure edits.
- CMS manuals.
- Outpatient Professional Payment System (OPPS) guidelines.
- Integrated Outpatient Code Editor (I/OCE) guidelines.
- Iowa state regulatory guidelines.

Quality monitoring programs

AmeriHealth Caritas Iowa will use several approaches to ensure claims and encounters are accurate and timely. Our dedicated Quality Auditing department will be accountable for reviewing adjudicated claims for financial, procedural and claim accuracy.

AmeriHealth Caritas Iowa will track encounter performance, as well as the performance of our subcontractors and providers. Our monitoring programs will help us achieve compliance with DHS encounter data reporting requirements, and highlight when follow up is required to resolve issues regarding encounter reporting by subcontractors or providers.

Reports will be regularly generated through our monitoring and audit programs and distributed to appropriate leadership and workgroups for review or necessary remediation activities. We will also perform a monthly internal credibility audit to validate the accuracy of auditing statistics.

Stratified health plan audit program

Every month, we will complete a stratified health plan audit, which consists of a random sample of at least 385 electronic and paper claims processed in the previous month. The payment strata will be adjusted depending on claims volume and then divided into three payment stratum, with a fourth stratum used for adjusted claims, and a fifth stratum for zero-paid claims. Parameters will be based on the previous year's historical data.

Claims pulled for stratified audits will consist of manually adjudicated and system adjudicated claims, as well as those handled by HP Quick Test Pro, a claims testing tool that processes routine claims that fall outside of our auto-adjudication process. The quality scores achieved for each plan will serve as the official score, which include financial, procedural and payment accuracy percentages. See Exhibit 12.4-A for an illustration of audit program results for one of our affiliate health plans.

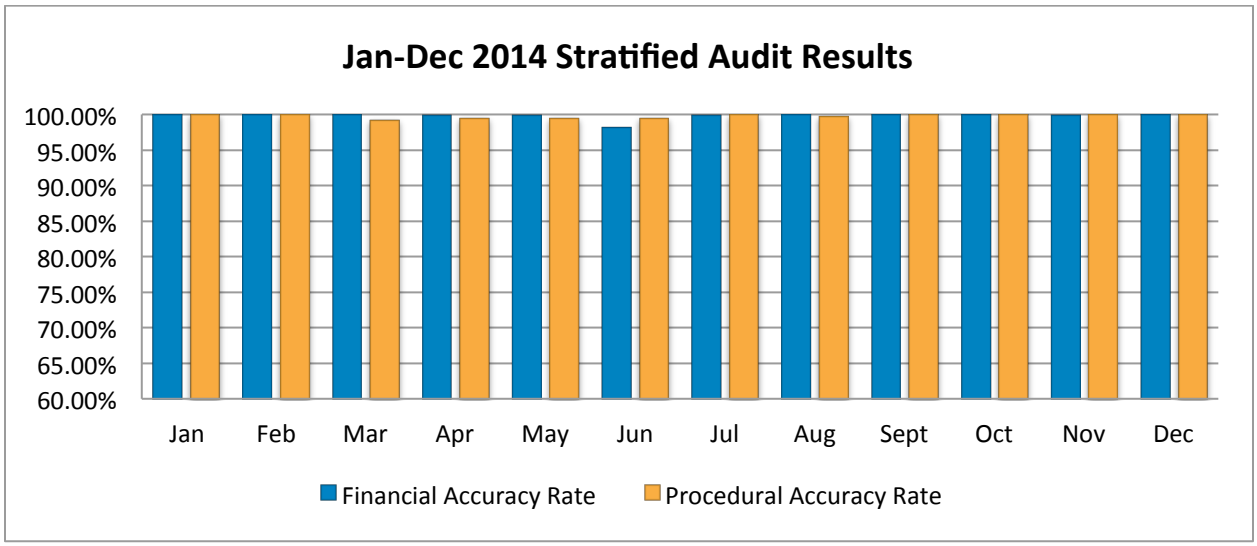

Exhibit 12.4-A: Stratified Audit Results from a Similar Plan We Manage

Monthly encounter status reports

Monthly status reports pulled from the encounter audit table will validate the integrity of the encounter data and overall system. Analysts will monitor the rejections on each error file received and use cumulative encounter error reports to identify trends.

Manually adjudicated audit program

On a daily basis, the selection for this audit will consist of a random sample of at least three percent of each claim examiner's processed work. Audits will be performed on a pre- or post-disbursement basis. The quality scores achieved for each claim examiner will serve as a performance management analysis for the claims operations management team. If a claims examiner needs further assistance, the claims management team will direct the auditor to pull a higher percentage of the individual's processed claims for an agreed-upon period.

Assisted adjudicated audit program

On a daily basis, a selection for this audit will consist of a random sample of at least one percent of claims processed through the HP Quick Test Pro. AmeriHealth Caritas Iowa utilizes an automated tool for batch claims reprocessing. This tool enables us to perform systematic payment updates to multiple claims when necessary, e.g., retro changes to updated fee schedules. This audit reviews processing of claims against specific adjustment criteria and plan-specific processing rules, and is also used to address provider claim payment issues (e.g., retrospective fee schedule adjustments) when multiple claims are impacted. Audit results are also used to identify process improvement opportunities.

Cost containment/Claim Reconciliation Recovery Unit audit program

For this daily audit, we will choose a random sample of at least 10 percent of monthly claims adjusted by the Claim Reconciliation Recovery Unit (CRRU) and at least three percent of monthly claims adjusted by the Cost Containment team. Audits will be performed on a pre- or post-disbursement basis. The quality scores of each examiner will serve as a performance management tool for the Cost Containment and CRRU management teams. Upon request from the CRRU/Cost Containment management teams, a higher percentage of an individual's processed claims can be pulled and audited for an agreed-upon period.

System adjudicated target audit program

The sample criteria for this audit will be based on claims management team requests, which may include previously identified quality auditing errors and recent configuration changes to the claim system (Facets). The sample will be focused on specific claim types and calculated to meet a minimum of a 95 percent confidence level and five percent precision level. Target audits will be performed on a pre- or post-disbursement basis as requested by the claims management team. Errors assessed during the target audit will be sent by the Quality Audit (QA) department to the Configuration and Claims Operations management teams for review.

High-dollar, pre-disbursement audit program

The criteria for this audit will be claims with total billed charges equal to or greater than $50,000. These claims will be reviewed by the QA team for procedural, financial and payment accuracy. Any identified discrepancies will be resolved prior to claim adjudication/payment.

New hire quality onboarding audit program

The selection for this audit will consist of a random sample, between five and 30 percent of the claims processed daily for each new associate, to identify performance gaps. The training program will be broken into three (3) modules for new associates to learn to process one type of claim and gain experience before moving on to another type. Modules exist for medical, hospital and COB claims. As each module of the training program concludes, the associate will begin processing that claim type in the production environment and the auditing periods begins. The first module is medical claim processing training. Subsequently, there is an audit period of three weeks, with a two-week period following the hospital and COB modules. The Quality Auditors may review errors with an associate up to two to three times per week, and with the trainer/supervisor at least once per week.

The quality scores achieved for each associate will serve as a performance management tool for the trainer and the claims management team. Upon completion of the “new hire” claims training and audit period, the associate will be monitored through the manually adjudicated audit program.

Claims payment subcontractor audit

AmeriHealth Caritas Iowa will collect “accuracy percentage” from the monthly delegation performance report submission required of all delegates. Additionally, we will ensure the delegate has approved procedures that include a process for reviewing claims for accuracy and acceptability. These policies will be reviewed by AmeriHealth Caritas Iowa during the annual delegation audit.

Local AmeriHealth Caritas Iowa review audit processes

In order to address errors in a timely manner, AmeriHealth Caritas Iowa will utilize a local quality auditor. This auditor will be responsible for the review of the lifecycle of all claims, contracting, configuration updates, fee schedule updates, provider maintenance, member reassignments and the monitoring of statutory reports/performances metrics from the Network Operations department. Audited information will be tracked and any discrepancies or identified claims issues will be reported at weekly meetings between Provider Network Operations (PNO) and the Claims Unit team. If updates or corrections are identified, the appropriate steps will be taken to address the issues as soon as possible. Additional staff within the PNO department will also audit the recoveries efforts, clinical editing and billing issues to ensure we are following standard Medicaid guidelines.

Documentation and reporting of audit results

The documentation of the audit results will reside in a dedicated database. The results for the monthly Stratified Plan Audit will be distributed to the Claims Operations management team on a monthly basis. The results for the manually adjudicated claim audit will be available to the Claims Operations management team in real-time, as the management team will have the access to pull quality audit results at any time, either by individual examiner or department. For both audits, the QA department will issue a claim summary report with the financial, procedural and claim accuracy scores for the month and a claim detail report to support claim errors identified in the audit.

Claim Detail Report for LOB 2100

Record Number	Claim Number	Paid Date	Paid Time	Paid Incorrect	Date Reviewed	Comments
		7/9/2014	Over Payment	$478.95	8/5/2014 6:34:18 AM	

Error Description	Error Comments	Error Type	Dispute Status	Dispute Level	Dispute Decision	Decision Comments
CLAIM Inappropriately Paid-Other	Claim paid incorrectly frequency code & submitted on claim. Per the Adjusted Claims Hospital rules, Void/Cancel of Prior Claim (this bill type is used for retractions), Deny all frequency 8 claims- X53, even if an EOB is attached to the claim	Financial				

Figure 12.4-B: Sample Stratified Plan Audit Report

Once the results are compiled, the Claims Operations team will access the results through a self-service reporting application. Reports will be available on a real-time basis and will include the following:

- Claim detail report by individual.
- Health plan summary report.
- Supervisor summary report.

Audit results will be utilized as a tool for the management staff of each claims team to identify trends and to enact procedures to remediate any identified errors. This will include, but not be limited to, individual coaching, targeted training (e.g., authorization, COB training) and progressive performance management. Results and any associated action plans will be reported to AmeriHealth Caritas Iowa's Quality of Service Committee and to the executive management team responsible for the plan.

Necessary corrective action processes

Claim Operations managers and supervisors will be responsible for reviewing the manually adjudicated (performance management) audit reports and determining if the errors are charged appropriately. If there is a discrepancy, the team lead will follow a formal appeals process to review the audit result. In addition, an internal credibility audit will be performed monthly to validate the accuracy of auditing statistics.

If the final monthly financial or procedural accuracy metrics do not meet our goal, the claims manager will develop an action plan, which will include a detailed analysis of the identified errors and a remediation plan. Action plans, which could include targeted refresher training, amended work aids and/or additional pre- and post-adjudication auditing, will be reviewed monthly and remain active until identified errors are resolved. Any claim payment error identified will be immediately corrected and reprocessed for appropriate payment.

Intervention for accuracy

Quality scores will be shared with the management team on a daily and monthly basis. If error trends are identified, targeted training modules will be developed. Depending on the nature of the errors, the entire claim staff may be required to attend the training. If the errors are isolated, the examiners who committed the errors will be required to attend the training.

Provider-reported payment errors will be handled by the Research and Analysis team, a specially trained unit within the Claims department. The Research and Analysis team will work with the provider to determine the root causes of the payment errors, such as system set-up or provider billing errors. Once the cause is determined, the team will implement appropriate remediation action, which may include education, system enhancements or claim examiner training.

5. Describe methods for verifying whether services reimbursed were actually furnished to members as billed by providers.

AmeriHealth Caritas Iowa will verify that services, for which a reimbursement was made, were provided to members via service verification letters. Service verification letters will be mailed monthly to members who receive claims within 45 days of payment. AmeriHealth Caritas Iowa will ensure that a minimum of one (1) percent of all paid claims in a given month is represented in the sample. If state requirements mandate a larger sample size, this requirement will be adjusted. To the extent that AmeriHealth Caritas Iowa considers a subset of providers or service types to warrant closer scrutiny, AmeriHealth Caritas Iowa will focus on claims received from targeted provider specialties, such as pain management, DME and home health.

On a monthly basis, we will track all service verification responses, related complaints received from members, resultant interventions and actions, and report results. Unreceived paid services will be forwarded to the DHS within the two business days.

Attachment 12.0-A: Draft AmeriHealth Caritas Iowa Compliance Program

Commitment to Compliance

AmeriHealth Caritas Iowa is dedicated to the highest standards of integrity and conducting business in an ethical and legal manner. Our Compliance Plan (the Program) will be implemented to assure we meet our legal and contractual requirements in Iowa. The Program promotes compliance with federal and state laws and regulations, fosters ethical conduct within the Company, and provides guidance to our employees, managers, senior executives, directors and contractors.

As part of the Program, AmeriHealth Caritas Family of Companies has adopted the Code of Ethics and Conduct (the “Code”), which will be adopted by AmeriHealth Caritas Iowa. The Code is a guide to acceptable and appropriate business conduct by the Company’s associates and contractors. All associates and contractors are expected to comply with the Code by respecting the principles and observing the rules of conduct described within the Code.

In addition, the Program describes our comprehensive plan for the prevention, detection and reporting of FWA. This includes the activities performed and procedures implemented by key departments throughout the organization. If violations of the Program or the Code occur, the plan will investigate the

matter, take disciplinary action, if necessary, and implement corrective measures to prevent future violations.

We have established a clear expectation of compliance with the Code, policies, DHS requirements and applicable laws, to reinforce the role of individual associates, suppliers, subcontractors, vendors, contracts and agents in maintaining an ethical and compliant workplace.

Scope

The Program and Code applies to all officers, directors, managers and associates, as well as suppliers, vendors, contractors, and agents who support the Medicaid business unit. The AmeriHealth Caritas Iowa Program is developed in accordance with 42 CFR 438.608, 42 CFR 455, Section 12 of the SOW and all relevant state and federal laws, regulations, policies, procedures and guidance, including CMS Guidelines for Performance Standard for Referrals of Suspected Fraud from a Single State Agency to a Medicaid Fraud Control Unit. AmeriHealth Caritas Iowa coordinates any and all program integrity efforts with IME personnel, DHS personnel and Iowa's Medicaid Fraud Control Unit (MFCU), located within the Iowa Department of Inspections and Appeals.

Purpose

The purpose of The Program is to ensure accountability and provide policies, procedures and standards to maintain compliance with federal and state requirements. The Program and Code activities support the following seven (7) key elements that facilitate the prevention, detection, reporting and corrective action for suspected cases of FWA in the administration and delivery of services under the state Medicaid Contract, as outlined in the following sections:

- Written standards, policies and procedures.
- Medicaid compliance officer and Compliance Committee.
- Effective training and education.
- Effective lines of communication/reporting mechanisms.
- Enforcement and disciplinary guidelines.
- Auditing and monitoring.
- Response to identified issues.

Components of the Compliance Plan

1.Written standards of conduct, policies and procedures

Policies and procedures

AmeriHealth Caritas Iowa maintains policies and procedures for the Compliance, Privacy and Program Integrity Programs. These policies and procedures ensure that all officers, directors, managers and associates know and understand what is required to ensure that AmeriHealth Caritas Iowa observes and maintains high standards of ethical conduct in its business and operational practices. Such policies and procedures include, but are not limited to:

- The Code of Ethics and Conduct.
- Implementation, operation, and communication of the Compliance Program.

- Procedures for detecting and preventing FWA.
- The AmeriHealth Caritas Iowa Employee Handbook, which contains specific discussions of the federal and state false claims, right of associates to be protected as whistleblowers and guidelines regarding HIPAA compliance.

As needed, AmeriHealth Caritas Iowa will develop new or revise policies in response to audit findings or new or revised regulations.

The AmeriHealth Caritas Iowa compliance officer, along with the Program Integrity department, will assist in the review and/or development of departmental policies and procedures, as needed.

2.Compliance Oversight

Governing authority: compliance officer

AmeriHealth Caritas Iowa will designate a compliance officer to serve as the coordinator of all compliance activities and who will be accountable to the AmeriHealth Caritas Iowa market president and may report any findings to the Board of AmeriHealth Caritas Iowa. The AmeriHealth Caritas Iowa compliance officer's responsibilities will include, but are not be limited to, the following:

- Development, implementation, operation and monitoring of the Program.
- Develop and obtain approval of an Annual Iowa Compliance & Privacy Work Plan.
- Ensuring that reports of noncompliance and suspected FWA are promptly and thoroughly investigated.
- Reporting quarterly, or more frequently as necessary, to the Compliance Committee on the effectiveness of the Program. Reports shall include payment integrity (cost avoidance and recoveries); SIU provider case identification, planning, action plans, and investigation summaries; compliance/privacy intakes; and other reports, as necessary to support the Program.
- Ensuring quarterly reporting to the Board of Directors of AmeriHealth Caritas Iowa.
- Participate in Corporate Compliance Committees.
- Reporting to the Compliance Committee and governing body on the status of compliance training.
- Implementation, distribution and compliance with policies and procedures as outlined in the Compliance Program.
- Development and implementation of training programs to ensure that AmeriHealth Caritas Iowa's officers, directors, managers, associates and other individuals are knowledgeable of the Compliance Program; its written Code of Conduct, related policies, and procedures; and the applicable statutory, regulatory and other requirements.
- Development and implementation of methods and programs that encourage managers and associates to report suspected fraud and other misconduct without fear of retaliation.
- Maintaining the compliance reporting mechanism and closely coordinating with the SIU, Internal Audit Department and other departments responsible for monitoring and auditing, where applicable.
- Responding to reports of potential instances of noncompliance and FWA, including the coordination of internal and external investigations and the development of appropriate corrective or disciplinary actions, if necessary. Participate as appropriate in the design and coordination of internal investigations (e.g., responding to reports of problems or suspected violations) and execute any

resulting corrective action (e.g., making necessary improvements to policies and practices and taking appropriate disciplinary action).

- Ensuring that the Department of Health and Human Services Office of Inspector General (DHHS OIG), General Services Administration (GSA), and any state exclusion lists as required by DHS have been checked with respect to all associates, officers, directors and managers, as well as first-tier, downstream and related entities.
- Coordinating with the Human Resources department and/or appropriate operational areas to ensure that appropriate action is taken when excluded individuals or entities are identified.
- Identification and prevention of payment of claims submitted by providers who have been excluded.
- Maintaining documentation for each report of noncompliance, potential FWA received through any of the reporting methods (i.e., hotline, mail, in-person) which describe the initial report of noncompliance, the investigation, the results of the investigation and all corrective and/or disciplinary action(s) taken as a result of the investigation, as well as the respective dates when each of these events and/or actions occurred and the names and contact information for the person(s) who took and documented these actions.
- The development and implementation of corrective action plans.
- Coordination of potential fraud investigations/referrals with DHS Office of the Inspector General (or equivalent), the state Medicaid Program Integrity Unit and the Medicaid Fraud Control Unit.

Compliance Committee

To assist the AmeriHealth Caritas Iowa compliance officer with his or her duties, AmeriHealth Caritas Iowa will establish a Compliance Committee that reviews compliance, privacy and FWA issues. The Committee will be comprised of senior management and has a primary objective to oversee the development and implementation of an effective and efficient compliance program that meets and exceeds our regulatory and contractual obligations. The duties and responsibilities of the Compliance Committee include, but are not limited to, the following:

- Meet at least quarterly with representatives from necessary operational and other departments.
- Review reports and recommendations of the compliance officer regarding compliance activities and makes recommendations regarding future compliance priorities and resources.
- In conjunction with the AmeriHealth Caritas Iowa compliance officer, provide input into the Annual Compliance & Privacy Work Plan.
- Set goals, monitor the progress of compliance and review major compliance issues identified by committee members.
- Engage in oversight activities related to correction of compliance risks and identification of areas for associate training and education.

3.Education and training

AmeriHealth Caritas Iowa's training systems will include education and guidance on our ethics and legal compliance policies, the Code of Conduct, FWA issues and procedures, and the reporting and investigation of compliance issues. This includes the use of a confidential toll-free telephone line for all associates, contractors and consultants. AmeriHealth Caritas Iowa has a policy concerning disciplinary action for noncompliance with the Code of Conduct.

AmeriHealth Caritas Iowa associates, including managers, directors and the Board of Directors who are involved with the administration or delivery of the Medicaid program, complete new hire training within 30 days of beginning date of employment in the following areas:

- Code of Ethics and Conduct.
- Privacy and Security, Health Insurance Portability and Accountability Act.
- FWA.
- Procedures for timely consistent exchange of information and collaboration with DHS.
- State-specific training on FWA and Whistleblower Protection.

As a condition of continued employment, every associate undergoes annual training on the Code of Ethics and Conduct. All associates are required upon hire, and annually thereafter, to complete False Claims Act (FCA) training, which highlights state and federal FCA requirements; the Deficit Reduction Act (DRA), the Fraud Enforcement and Recovery Act (FERA), the Affordable Care Act (ACA) and the Dodd-Frank Act. Through this course, associates are educated on the FCA and its pertinence to fraud and abuse in Medicaid programs. They are alerted to specific provisions for whistleblower protections and are provided with resources to help them remain compliant with federal and state FCA laws.

The training program also includes our SIU's mission and purpose, identification of suspicious FWA scenarios and the SIU referral process. The provisions of the targeted FWA and other related training are provided by SIU upon request, or otherwise as necessary.

As with other AmeriHealth Caritas plans, AmeriHealth Caritas Iowa will provide additional training to its employees via quarterly associate education sessions and quarterly compliance newsletters. Topics vary from compliance and ethics to FWA reporting to DHS contract requirements.

In furtherance of AmeriHealth Caritas Iowa's commitment to FWA, SIU staff members are provided training opportunities to enhance their skill set and knowledge base. Investigators attend in-person and online education and training provided through the National Health Care Anti-Fraud Association.

AmeriHealth Caritas Iowa providers and subcontractors shall agree to conduct their own compliance FWA training for all associates in accordance with Iowa rules and regulations, and shall conduct such training within 30 days of hire and annually thereafter. Additionally, we will make our Compliance and FWA training available to first tier, downstream and related entities, so that it can be used as a resource for meeting the requirement that they provide compliance and FWA prevention training to their associates.

4.Communication and systems

AmeriHealth Caritas Iowa is committed to encouraging open lines of communication for asking compliance questions and raising compliance concerns between the AmeriHealth Caritas Iowa Compliance Officer, associates, senior managers, Board of Directors and contractors, including all subcontracted entities.

Internal reporting mechanisms

Any associate or contractor may make an inquiry or report of unethical activity, activity inconsistent with the Code, corporate policies or law or noncompliance with other program requirements. The Program supports effective lines of communication by reporting through available resources, including managers, senior management, AmeriHealth Caritas Iowa compliance officer and the organization's toll-free hotline. The hotline is available to associates, contractors and members to report a suspected violation of the Program, the Code, a law or regulation or any AmeriHealth policy. The Compliance Hotline (1-800-575-0417) is available 24 hours a day, seven (7) days a week. We also have established a FWA hotline (1-866-

833-9718) that is available to associates and contractors 24 hours a day, seven (7) days a week. Potential compliance issues may be used for anonymous and confidential reporting.

All associates and contractors are required to report known or suspected noncompliance and, as necessary, assist in the resolution of identified issues. Failure to report suspected violations, misconduct or noncompliance violates the Code and the expectations of all associates. Failure to report is grounds for associate and contractor disciplinary action, including termination. AmeriHealth Caritas Iowa expressly prohibits retaliation for good faith reports as part of its non-retaliation policy. Reports of noncompliance can be made anonymously. To the extent possible, AmeriHealth Caritas Iowa will take reasonable precautions to maintain the confidentiality of those who report compliance concerns. We also encourage reporting of potential FWA through the Provider and Member Handbooks.

Communication with Iowa State Program Integrity/Medicaid Fraud Units

AmeriHealth Caritas Family of Companies and AmeriHealth Caritas Iowa will establish monthly reporting, including both payment integrity (cost avoidance and recoveries), and SIU provider case identification, planning and action plans. AmeriHealth Caritas Iowa will report possible FWA activity to the Agency. AmeriHealth Caritas Iowa will initiate an immediate investigation to gather facts regarding potential fraud or abuse. Documentation of the findings will be delivered to the Agency within two (2) days of the identification of suspected FWA activity. AmeriHealth Caritas Iowa's SIU is prepared to meet any additional reporting timeframes in the matter and format deemed appropriate by the state.

This organizational alignment provides transparency for all Program Integrity and SIU activities and findings. In addition, the SIU director, in conjunction with the designated AmeriHealth Caritas Iowa compliance officer, ensures timely reporting and ongoing updates to the MFCU through DHS, and in accordance with the state Medicaid contract, also brings forward investigation summaries to the Compliance Committee. AmeriHealth Caritas Iowa will communicate monthly and as required with the Agency Program Integrity Unit, DHS staff, and MFCU staff when necessary.

The SIU Director reviews and addresses requests for information relating to FWA, including, but not limited to losses, recoveries and provider terminations. In accordance with policy and procedure, prior to a FWA provider termination decision being made by AmeriHealth Caritas Iowa, the SIU director and compliance officer may consult with multiple stakeholders, including AmeriHealth Caritas Iowa's leadership, provider network management, operations, credentialing and risk management leaders, to ensure that all affected systems are updated and peer review can take place if it is warranted. Legal Affairs may also provide advice when required.

Reporting will include, but is not limited to:

- The name and NPI of provider reviewed.
- The reason for the review, data source and/or referral.
- Review outcome.
- Provider referrals to MFCU.
- Providers suspended and reason for suspension.
- Providers terminated and reason for termination.
- Provider recoupment amount and reason for recoupment.
- Provider payment reductions and reason for payment reduction.
- Providers who were denied enrollment or reenrollment pursuant to 42 CFR 455, including name, NPI and reason for denial.
- State fiscal year to date summary information of Contractor Program Integrity activity.

Upon request, AmeriHealth Caritas Iowa will provide any and all documentation or information to the Agency, the MFCU, HHS-OIG or the US Department of Justice related to any aspect of the Contract, including but not limited to policies, procedures, subcontracts, provider agreements, claims data, encounter data, provider records and report on recoupment actions and receivables.

AmeriHealth Caritas Iowa will not take action to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services or claim upon the withhold or recoupment meet the criteria outlined by DCH.

Referral to Law Enforcement

Where applicable and permitted, the SIU pledges full cooperation with local, state and federal law enforcement agencies, as well as with state Insurance Fraud Departments, state Medicaid Fraud Control Units and state Medicaid Program Integrity Units in the prosecution of all fraud cases. The primary goal of referring a case to a law enforcement agency is to obtain a conviction. If the prosecution is successful, restitution will be consistently pursued as an element of judgment in coordination with state and federal victim protection boards.

The SIU will refer to law enforcement any transaction where the facts and circumstances create a reasonable belief that a person or entity may have committed or is committing fraud and/or abuse. A referral to a law enforcement agency will be submitted in a standardized format or as mandated by a particular law enforcement agency.

The SIU will refer suspected or confirmed FWA, in addition to neglect/abuse (mistreatment) of a member, to the appropriate agencies within the required timeframes.

5.Auditing and Monitoring

The AmeriHealth Caritas Iowa Compliance Department, in conjunction with Internal Audit Department supports the organization by engaging in compliance audits pursuant to an approved auditing and monitoring plan. The purpose of the auditing and monitoring activities is to ensure the business and associated contracted entities are meeting expectations and the requirements of state and federal regulations.

Contract compliance

AmeriHealth Caritas Iowa will conduct contract compliance monitoring reviews and document results of compliance with all DHS Contract requirements. We will complete assessments and implement any necessary remedies to meet contractual requirements. The AmeriHealth Caritas Iowa compliance officer will ensure the creation of an accurate and up-to-date contract monitoring tool. This tool will be updated with new or changed contract requirements resulting from the annual contract language negotiation process, or as needed.

Monitoring of Iowa regulations

The AmeriHealth Caritas Iowa compliance officer will oversee monitoring of regulatory notices and changes in federal regulations and ensure compliance with new regulations/requirements. The contract monitoring tool will be updated accordingly to ensure adherence to state and federal regulations.

Privacy inspections

The AmeriHealth Caritas Iowa compliance officer will perform quarterly HIPAA inspections of associates' work areas and public spaces. Reports will be submitted in a timely fashion to outline the results of all

completed inspections. The HIPAA inspection process will be completed for the AmeriHealth Caritas Family of Companies' Philadelphia campus, as well as the AmeriHealth Caritas Iowa local office.

Sanction screening

Employees and Providers

All prospective associates are required to undergo pre-employment background check and mandatory drug screens prior to employment. AmeriHealth Caritas screens prospective vendors as well as current vendors and employees by checking the U.S. Department of Health and Human Services (HHS) Office of Inspector General (HHS- OIG) List of Excluded Individuals/Entities (LEIE), the U.S. General Services Administration's (GSA) web-based Excluded Parties List System (EPLS), U.S. Treasury Department Office of Foreign Assets List of Specially Designated Nationals and Blocked Persons, and applicable state exclusion lists for names of excluded associates, contractors, providers and vendors barred from participation in Medicare, Medicaid, other federal health care programs, federal contracts and state health care program.

Excluded individuals/entities are not hired, employed or contracted to provide services for AmeriHealth Caritas Family of Companies' product offerings.

6.Enforcement

Disciplinary policies and procedures

AmeriHealth Caritas Iowa establishes clear expectations of compliance with the Code of Ethics and Conduct. The Code of Ethics and Conduct, employee handbook and various other documents require associates, supplier, vendors and contractors to identify non- compliance and unethical behavior.

Disciplinary guidelines are provided to associates in the Code of Ethics and Conduct and other guidelines, including but not limited to the Disciplinary Action for Noncompliance with the Company's Standards of Conduct, Progressive Disciplinary and the Sanctions for Violating HIPAA Privacy and Security policies. This information is also available to all associates on the AmeriHealth intranet site.

Violations may be grounds for termination or other disciplinary action, depending on the circumstances of each violation as determined by the Human Resources Department in consultation with the AmeriHealth Caritas Iowa Compliance Officer or designee.

7.Response and Prevention

Investigations

As described above, the AmeriHealth Caritas Iowa SIU establishes, distributes, enforces and revises, as necessary, written policies and procedures to be used by the SIU staff to detect, investigate, and fully document allegations of FWA. This includes a procedure to report evidence of misconduct or noncompliance to DHS and other agencies. All investigations are performed in a uniform, timely and complete manner.

Investigations of any compliance related matter include interviews, review of source documents, review of regulatory requirements, the Code and policies and procedures, and responses to requests for information from individuals or organizations who may possess relevant information. Our investigators document investigations with various information, including but not limited to:

- The source of the investigation.
- The investigation results and findings.

- Recommendations for remedial action where appropriate.
- Communications to affected parties.
- Final resolution of the matter.

The AmeriHealth Caritas Iowa compliance officer and Program Integrity departments document issues and results of investigation and report to Management and Committee, as needed.

Response to investigations

In the event that an investigation identifies FWA, misconduct, violation of applicable laws or regulations, or noncompliance with Medicaid program requirements, AmeriHealth Caritas Iowa will take prompt appropriate action, including but not limited to, the following:

- For associates, when warranting an investigation, the Compliance Officer consults with the Human Resources department to determine appropriate action in accordance with the Code and other applicable policies and procedures.
- For contractors, when warranting an investigation, AmeriHealth Caritas Iowa management will identify appropriate disciplinary or corrective action in accordance with the contractor's contract, up to and including termination of the contract.
- Corrective action plans (CAPs) are developed based on investigative findings and are designed to correct underlying problems that resulted in program violations and prevent future program violations or misconduct. Depending on the circumstances, CAPs may involve repayment of overpayments, disciplinary action or other remediation in response to the violation. Each CAP is tailored to address issues identified in the investigation, provide structure and timeframes for completion, and is monitored and tracked to ensure that the corrective action is fully implemented in a timely manner.
- Training and education to prevent recurrence of program violations or misconduct may include training and education of associates and contractors. Such training and education may be provided as needed to individuals, groups, business areas or contractors.
- The Compliance Department and affected business areas will conduct monitoring and auditing activities to ensure effective resolution of issues identified during an investigation. The annual audit plan may be revised to incorporate additional audit activities determined to be necessary as a result of the investigations.

Voluntary self-reporting and referrals to law enforcement, governmental authorities and/or DHS will be enforced, as appropriate. AmeriHealth Caritas Iowa will report instances of potential FWA, misconduct and/or noncompliance related to the Medicaid program. As investigations warrant, AmeriHealth Caritas Iowa will partner with state and federal law enforcement, regulatory agencies and other insurance companies, as appropriate. In addition, at the conclusion of an investigation related to the Medicaid program, if AmeriHealth Caritas Iowa determines that potential fraud or misconduct by entities not affiliated with the company has occurred, the matter will be promptly referred to the DHS